COPY

-Application

Erlanger Health System

CN1502-005

CERTIFICATE OF NEED APPLICATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger East Hospital

Application To Modernize The Certificate Of Need

Originally Issued In 2004 (No. CN0405-047AE)

By Upgrading the Cardiac Catheterization Lab To Perform

Interventional / Therapeutic Procedures In The Already

Approved Diagnostic Cardiac Catheterization Laboratory

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Section A

APPLICANT PROFILE

Section A: APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate "N/A". ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable item Number on the attachement.***

1. Name of Facility, Agency, or Institution.

Chattanooga-Hamilton County Hospital Authority
D / B / A
Erlanger East Hospital
1755 Gunbarrel Road
Hamilton County
Chattanooga, TN 37416

2. Contact Person Available For Responses To Questions.

Joseph M. Winick, Sr. Vice President
Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403
(423) 778-8088
(423) 778-7525 -- FAX
Joseph.Winick@erlanger.org -- E-Mail

3. Owner of the Facility, Agency, or Institution.

Chattanooga - Hamilton County Hospital Authority
D / B / A
Erlanger Health System
975 East 3rd Street
Hamilton County
Chattanooga, TN 37403
(423) 778-7000

4. Type of Ownership or Control.

A. Sole Proprietorship _____
B. Partnership _____
C. Limited Partnership _____
D. Corporation (For Profit) _____

E.	Corporation (Not-for-Profit)	
F.	Governmental (State of TN or Political Subdivision)	X
G.	Joint Venture	
H.	Limited Liability Company	
I.	Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

-- A copy of the enabling legislation along with a copy of the certification by the Tennessee Secretary of State is attached at the end of this Application.

-- Please note that *Erlanger Health System* is a single legal entity and *Erlanger East Hospital* is an administrative unit of *Erlanger Health System*.

5. Name of Management / Operating Entity (if applicable).

*** Not Applicable. ****

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. Legal Interest in the Site of the Institution

(Check One)

A.	Ownership	X
B.	Option to Purchase	
C.	Lease of _____ Years	
D.	Option to Lease	
E.	Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. Type of Institution

(Check as appropriate - more than one response may apply)

A.	Hospital (Specify) General Medical / Surgical	X
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	
C.	ASTC, Single Specialty	
D.	Home Health Agency	
E.	Hospice	
F.	Mental Health Hospital	
G.	Mental Health Residential Treatment Facility	
H.	Mental Health Institutional Habilitation Facility (ICF/MR)	
I.	Nursing Home	
J.	Outpatient Diagnostic Center	
K.	Recuperation Center	
L.	Rehabilitation Facility	
M.	Residential Hospice	
N.	Non-Residential Methadone Facility	
O.	Birthing Center	
P.	Other Outpatient Facility (Specify)	
Q.	Other (Specify)	

8. **Purpose of Review**

(Circle Letter(s) as appropriate - more than one response may apply)

A.	New Institution	
B.	Replacement/Existing Facility	
C.	Modification/Existing Facility	
D.	Initiation of Health Care Service As Defined In TCA § 68-11-1607(4) (Specify)	
E.	Discontinuance of OB Services	
F.	Acquisition of Equipment	
G.	Change in Beds [*Please note the type of change by underlining the appropriate response:* Increase, Decrease, Designation, Distribution, Conversion, Relocation]	
H.	Change of Location	
I.	Other (Specify) Modernize CON No. CN0405-047AE To Upgrade Cardiac Catheterization Lab To Perform Interventional Cardiac Procedures	X

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Licensed Beds	*(*) CON Beds*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical	12	44	12	56	56
B.	Surgical	6	22	6	28	28
C.	Long-Term Care Hospital					
D.	Obstetrical	25		25	25	25
E.	ICU / CCU		4		4	4
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child / Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (Non – Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid / Medicare)					
P.	ICF / MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	43	70	43	113	113

(*) CON Beds approved but not yet in service.

Notes

(1) *Erlanger East Hospital* also holds a CON for the transfer of up to 79 additional beds from *Erlanger Medical Center* (no. CN0405-047AE). Nine (9) beds have already been implemented in this process.

(2) *Erlanger East Hospital* also received a CON to transfer six (6) beds from *Erlanger Medical Center* (no. CN0407-067A).

(3) *Erlanger East Hospital* operates as a satellite facility of *Erlanger Medical Center* under the Tennessee Dept. of Health - License No. 000140.

10. Medicare Provider Number 044-0104

Certification Type General Medical/Surgical

11. Medicaid Provider Number 044-0104 (** See note.)

Certification Type General Medical/Surgical

** Please note that the same provider number for Medicare has been shown for Medicaid as well. This is because the individual TennCare MCO's each assign their own particular provider ID numbers. *Erlanger East Hospital* is licensed, and operates as, a satellite facility of *Erlanger Medical Center*.

12. If this is a new facility, will certification be sought for Medicare and / or Medicaid ?

Yes _____ No _____

** *Not Applicable - Erlanger East Hospital* currently participates in both the Medicare and TennCare/Medicaid programs as a satellite facility of *Erlanger Medical Center*.

***13. Identify all TennCare Managed Care Organizations / Behavioral Health Organizations (MCO's/BHO's) operating in the proposed service area.* Will this project involve the treatment of TennCare participants ?** *Yes* **If the response to this item is yes, please identify all MCO's/BHO's with which the applicant has constracted *or plans to contract*.**

Discuss any out-of-network relationships in place with MCO's/BHO's in the area.

Response

With the initiation of the *Health Care Exchanges* under the *Affordable Care Act* on January 1, 2014; *Blue Cross Network E* enrolled over 10,000 uninsured people; *Erlanger* is the exclusive provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S*, where *Erlanger* is one of two providers in this

network. *Erlanger* is the low cost and safety net provider in the regional service area and participates in narrow networks to facilitate needed care for those who would otherwise not access to needed healthcare services.

Erlanger currently has contracts with the following entities.

A. TennCare Managed Care Organizations

-- BlueCare
-- TennCare *Select*
-- AmeriGroup Community Care
-- United Healthcare e

B. Georgia Medicaid Managed Care Organizations

-- AmeriGroup Community Care
-- Peach State Health Plan
-- WellCare Of Georgia

C. Commercial Managed Care Organizations

-- Blue Cross / Blue Shield of Tennessee
  - Blue Network P
  - Blue Network S
  - Blue Network E
  - Blue CoverTN
  - Cover Kids
  - AccessTN
  - Blue Advantage
-- Blue Cross of Georgia (HMO & Indemnity)
-- Bluegrass Family Health, Inc.
  (includes Signature Health Alliance)
-- CIGNA Healthcare of Tennessee, Inc.
  (includes LocalPlus)
-- CIGNA Lifesource (Transplant Network)
-- UNITED Healthcare of Tennessee, Inc.
  (Commercial & Medicare Advantage)
-- Aetna Health
-- Health Value Management D/B/A Choice Care Network (Commercial & Medicare Advantage)
-- HUMANA
  (Choicecare Network, HMO, PPO, POS & Medicare Advantage)
-- HUMANA Military
-- Community Health Alliance
-- HealthSpring (Commercial & Medicare Advantage)

-- Windsor Health Plan (Medicare Advantage)
-- Olympus Managed Health Care, Inc.

D. Alliances

-- Health One Alliance

E. Networks

-- Multi-Plan (includes Beech Street & PHCS)
-- MCS Patient Centered Healthcare
-- National Provider Network
-- NovaNet (group health)
-- USA Managed Care Corp.
-- MedCost
-- Alliant Health Plan
-- Crescent Preferred Provider Organization
-- Evolutions Healthcare System
-- Prime Health Resources
-- Three Rivers Provider Network
-- Galaxy Health Network
-- First Health Network
-- Integrated Health Plan
-- Logicomp Business Solutions, Inc.
-- HealthSCOPE Benefits, Inc.
-- HealthCHOICE (Oklahoma State & Education Employees Group Insurance Board)

F. Other

-- Alexian Brothers Community Services

Section B

PROJECT DESCRIPTION

Section B: PROJECT DESCRIPTION

Please answer all questions on 8 ½" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response

In 2004, *Erlanger East Hospital* applied for and received approval for a certificate of need (No. CN0405-047AE) for 79 additional beds and also the expansion of services to include a Cardiac Catheterization Lab for diagnostic procedures. The project has been implemented in phases with several extensions granted for this CON in the intervening 10 years since initial approval. The original application was based on *Criteria And Standards* developed in 2000 and these standards were updated in 2009. Since the original application was approved in 2004, and since the updated standards were promulgated in 2009; both technology and clinical practices have changed dramatically for certain categories of patients. Given the time span since original approval, *Erlanger East Hospital* has a need, and seeks approval, to modernize its facility plan for this final phase of the expansion project. In a similar fashion, a CON application was submitted in December, 2014, for *Erlanger East Hospital* seeking approval to initiate a satellite radiation therapy service along with the relocation of a Linear Accelerator from *Erlanger Medical Center* (no. CN1412-048). Additional initiatives are being evaluated that may require further review in coming months for additional "*change of scope*" services.

Due to changes in technology and within the realm of clinical practice for patients to be treated for cardiac

catheterization, *Erlanger East Hospital* now seeks approval to modernize the CON originally approved in 2004. The original CON granted approval for *diagnostic* cardiac catheterization procedures at *Erlanger East Hospital*; now we seek approval to modernize that service to include therapeutic cardiac catheterization procedures. This is a reflection of the currently accepted practice of treating a "low risk diagnostic" catheterization patient with a "therapeutic" intervention during the same procedure when such an intervention is identified as necessary. Within this framework, the medical director of our Cardiology service has indicated that it is safer to do the procedure concurrently than to transfer such a patient to another hospital where a second intervention would be required. It should be noted that the *HSDA* has already granted approval for a similar project with *Dyersburg Regional Medical Center* (no. CN1403-007) to upgrade its cardiac catheterization laboratory to include interventional procedures.

Erlanger East Hospital is licensed, and currently operates as, a satellite facility of *Erlanger Medical Center*. Within this framework, the clinical skills of staff members are transferable between the new laboratory at *Erlanger East Hospital* and the existing laboratory at *Erlanger Medical Center*. It should be noted that cardiac catheterization is a core competency of *Erlanger Health System*. While at *Erlanger Medical Center* or *Erlanger East Hospital*, staff members may be rotated between both locations. Both hospitals are located within the same county. Such rotation will provide synergy for the cardiac catheterization service line within *Erlanger Health System*.

While *Erlanger East Hospital* will not perform cardiac surgery, a recent study by the Atlantic CPORT E-Trials published in the New England Journal of Medicine in December, 2014, found that "PCI performed at hospitals without on-site cardiac surgery was noninferior to PCI performed at hospitals with on-site cardiac surgery". A copy of this article is attached to this CON application.

Proposed Services & Equipment

Erlanger East Hospital seeks to modernize the original CON approved in 2004 by upgrading the cardiac catheterization service from diagnostic procedures to include interventional procedures. *Erlanger East Hospital* will implement and follow a strict protocol

to ensure that only patients with low risk have procedures performed.

Ownership Structure

The *Chattanooga-Hamilton County Hospital Authority* is a governmental unit of the *State of Tennessee*, created by a private act of the *Tennessee General Assembly* in 1976. The hospital authority does business under the trade names of *Erlanger Health System*, *Erlanger Medical Center* and *Erlanger East Hospital*, among others. As a governmental unit, there are no "owners", per se, other than the people and general public of the *State of Tennessee*.

Service Area

The service area for this project is defined as the ten (10) zip codes, as follows … 30736-Ringgold, GA; 30742-Fort Oglethorpe, GA; 37302-Apison, TN; 37341-Harrison, TN; 37353-McDonald, TN; 37363-Ooltewah, TN; 37411-Chattanooga, TN; 37412-East Ridge, TN; 37416-Chattanooga, TN; 37421-Chattanooga, TN. These zip codes comprise East Hamilton County and West Bradley County in Tennessee, along with 2 zip codes from Catoosa County in Northwest Georgia.

Need

The need for the cardiac catheterization service at *Erlanger East Hospital* has already been demonstrated. We estimate the following volume of low risk interventional catheterization patients at *Erlanger East Hospital*.

	Interventional Patients	Existing Patients	New Patients
Year 1	127	71	56
Year 2	132	74	58

Existing Resources

Within the service area, cardiac catheterization services are not currently performed at any other hospital.

Project Cost

The project cost is estimated to be $ 303,000. This cost is intended to cover miscellaneous clinical equipment necessary to update the laboratory consistent with current standards.

Funding

The funding for this project will be provided from operations of *Erlanger Health System*. The CFO letter is attached to this CON application.

Financial Feasibility

The *Projected Data Chart* shows that this project is financially viable in both years 1 and 2.

Staffing

Staffing for the cardiac catheterization service will include 4 Cardiovascular Specialists.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and / or renovation to the facility (exclusive of major medical equipment covered by T.C.A. section 68-11-1601 *et seq.*) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $ 5 million) and other facility projects (construction cost in excess of $ 2 million) should complete the Square Footage And Cost Per Square Foot Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Part B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above

describe the development of the proposal.

Response

The cardiac catheterization service at *Erlanger East Hospital* has already been approved (no. CN0405-047AE). There will be no new construction or modifications to existing facilities as a result of this project. The cardiac catheterization laboratory will be located in a total of 1,400 SF with 808 SF for the catheterization procedure room and the remaining 598 SF for support spaces. Please see the schematic diagram attached to this CON application.

B. Identify the number of beds increased, decreased, converted, relocated, designated, and/or distributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response

No acute care beds will be affected by this project. *Erlanger East Hospital* also holds a CON for the transfer of up to 70 additional beds from *Erlanger Medical Center* (no. CN0405-047AE). The expansion of *Erlanger East Hospital* has occurred in phases and is in process.

Square Footage & Cost Per Square Foot Chart

The *Square Footage & Cost Per Square Foot Chart* is not applicable to this CON application.

C. As the applicant, describe your need to provide the following healthcare services (if applicable to this application):

1.	Adult Psychiatric Services	N/A
2.	Alcohol and Drug Treatment for Adolescents (exceeding 28 days)	N/A
3.	Birthing Center	N/A
4.	Burn Units	N/A
5.	Cardiac Catheterization Services	*** See Below.*

6.	Child and Adolescent Psychiatric Services	N/A
7.	Extracorporeal Lithotripsy	N/A
8.	Home Health Services	N/A
9.	Hospice Services	N/A
10.	Residential Hospice	N/A
11.	ICF/MR Services	N/A
12.	Long-Term Care Services	N/A
13.	Magnetic Resonance Imaging (MRI)	N/A
14.	Mental Health Residential Treatment	N/A
15.	Neonatal Intensive Care Unit	N/A
16.	Non-Residential Methadone Treatment Centers	N/A
17.	Open Heart Surgery	N/A
18.	Positron Emission Tomography	N/A
19.	Radiation Therapy/Linear Accelerator	N/A
20.	Rehabilitation Services	N/A
21.	Swing Beds	N/A

Response

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D. Describe the need to change location or replace an existing facility.

Response

*** Not applicable.*

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $ 2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed site major medical equipment (not replacing existing equipment).

   a. Describe the new equipment, including:

      1. Total Cost (as defined by Agency Rule).
      2. Expected useful life.
      3. List of clinical applications to be provided.
      4. Documentation of FDA approval.

   Response

   ** *Not applicable.*

   b. Provide current and proposed schedules of operations.

   Response

The schedule of operation for the cardiac catheterization service at *Erlanger East Hospital* will be 7:00 am - 5:00 pm, Monday - Friday.

2. For mobile major medical equipment:

   a. List all sites that will be served.
   b. Provide current and proposed schedules of operations.
   c. Provide the lease or contract cost.
   d. Provide the fair market value of the equipment.
   e. List the owner for the equipment.

   Response

The equipment for the cardiac catheterization service at *Erlanger East Hospital* was approved with the original CON. We have budgeted $ 300,000 for miscellaneous and support equipment for the modernization of this service. This is similar to the CON application for *Dyersburg Regional Medical Center*.

3. Indicate applicant's legal interest in equipment (i.e.-purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response

The equipment for the cardiac catheterization service at *Erlanger East Hospital* was approved with the original CON. However, we have budgeted $ 300,000 to upgrade and modernize miscellaneous clinical equipment related to this service, if necessary. This is consistent with the CON application for *Dyersburg Regional Medical Center*.

III. (A) Attach a copy of the plot plan of the site on an 8 ½" x 11" sheet of white paper which **must include**:

1. Size of site (**in acres**).

-- The *Erlanger East Hospital* campus is located on approximately 26.8 acres. A copy of the plot plan is attached to this CON application.

2. Location of structure on the site.

-- Please see the location of the cardiac catheterization laboratory on the *Erlanger East Hospital* campus on the schematic drawing attached to this CON application.

3. Location of the proposed construction.

-- 1755 Gunbarrel Road
Chattanooga, TN 37416

4. Names of streets, roads or highways that cross or border the site.

-- Roads that border the site are *Gunbarrel Road* and *Crane Road*.

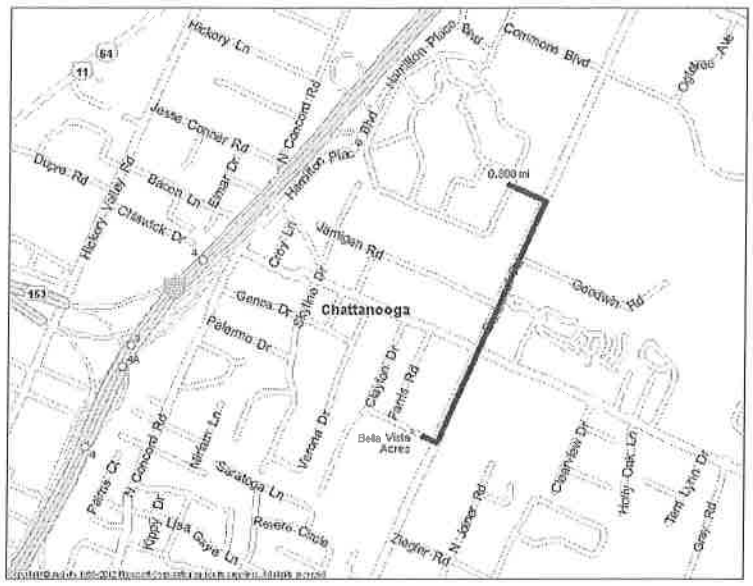
Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response

Erlanger East Hospital is easily accessible to patients in Chattanooga and Hamilton County as well as the surrounding service area; from both primary and secondary roads. Additionally, the hospital can be easily accessed via public transportation. Proximal state and interstate highways provide easy access from Tennessee, Georgia, Alabama and North Carolina.

The distance from *Erlanger East Hospital* to *Hamilton Place Mall* is 8/10 of a mile, as evidenced by the map below. *Hamilton Place Mall*, a regional shopping center in Chattanooga, is the largest mall in the *State of Tennessee*. Public transportation is easily accessible to Gunbarrel Road. Further, Interstate 75 is a major highway and is also within 8/10 of a mile.



IV. Attach a floor plan drawing which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc., on an 8 ½" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

Response

A copy of the floor plan is attached to this CON application.

V. For a Home Health Agency or Hospice, identify:

A. Existing service area by County.
B. Proposed service area by County.
C. A parent or primary service provider.
D. Existing branches.
E. Proposed branches.

Response

*** Not applicable. ***

Section C

GENERAL CRITERIA FOR CERTIFICATE OF NEED

Section C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines For Growth), developed pursuant to Tennessee Code Annotated § 68-11-1625.

The following questions are listed according to the three (3) criteria: (1) Need, (2) Economic Feasibility, and (3) Contribution to the Orderly Development of Healthcare. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on 8 ½" x 11" white paper.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)".

PRINCIPLES OF TENNESSEE STATE HEALTH PLAN

[From 2011 Update, Pages 5-13]

1. *Healthy Lives*: The purpose of the State Health Plan is to improve the health of Tennesseans.

Response

Erlanger East Hospital ("*EEH*") is a satellite facility of *Erlanger Medical Center* ("*EMC*"), the safety net hospital for southeast Tennessee; though the hospital also serves northwest Georgia, northeast Alabama and southwest North Carolina due to it's location and the scope and range of services provided. It is often the only health system which low-income people, minorities, and other underserved populations can turn to for treatment. In order to assure the continued viability of its mission as a safety net hospital, *Erlanger* continually strives to provide services

that are the most medically appropriate, least intensive, and provided in the most cost-effective health care setting.

As the safety net provider, a large underserved population depends on *Erlanger* to provide needed services. While it is difficult to predict the outcome of health reform initiatives, many Tennesseans previously without health insurance can be expected to elect services which may have otherwise been postponed. Growth in the elderly and general population can be expected to increase demand for caridiac services. Surveys of the Chattanooga region have shown that some 70% or more of area physicians and surgeons received their training at *Erlanger* via its affiliation with the UT College of Medicine, which is co-located on the *Erlanger Medical Center* campus. Based on current residency and fellowship programs, it can be expected that this trend will continue with many physicians opting to remain in Tennessee, at *Erlanger.*

The proposed modernization of the cardiac catheterization service is consistent with the *State Health Plan* because it seeks to ensure patient access to appropriate facilities for Tennesseans in particular. *Erlanger* is the safety net for underserved residents in southeast Tennessee, including the only Children's Hospital within 100 miles of Chattanooga, Tennessee. Providing enhanced access for those in need of chronic care regardless of the patients' ability to pay has been demonstrated to improve the health status of those served.

The Chattanooga region, particularly Enterprise South Industrial Park, located less than 10 minutes away from *Erlanger East Hospital* has proven attractive to business development due to the relatively low cost of labor, cost of living and absence of personal income tax. Also, Chattanooga has been recognized as one of the tenth lowest cost markets from a health care insurance perspective since the roll out of the *Affordable Care Act* and the insurance exchange marketplace.

Volkswagen recently announced that it will invest $800 million in its Chattanooga manufacturing plant, adding a second automobile line to its production facility. In doing so, Volkswagen expects to employ an additional 2,000 employees, with the goal to have the second production line up and running in 2016. *Erlanger* has a primary care site

on the Volkswagen campus that serves employees and their families as well as others in the community. Volkswagen also has preferred employer status with *Erlanger*, whereby employees receive a discount when services are provided. With this expansion, parts, paint and other suppliers involved with the manufacturing are also expected to add employees. Volkswagen has released an additional 300 acres of property to house as many as twenty additional supply companies, increasing site employment to 7,500.

Plastic Omnium Auto Exteriors, LLC, a tier one supplier for Volkswagen, also recently announced that it will make a $65 million investment in Chattanooga, creating nearly 200 new positions at opening, with a target of 300 positions within three years. The company has purchased 27 acres in the industrial park where VW is located.

NV Michel Van De Wielke, one of the largest manufacturers of textile machines in the world indicated it would relocate to Chattanooga from Dalton, GA, to be closer to marketplace competitors and challenge rivals for market share. The plant will employ 35. Chattanooga is the birthplace of tufting with a long tradition in the flooring industry and many manufacturers are still in the region. The company will also relocate its headquarters from Charlotte, NC, to Chattanooga.

On the health front, area hospitals have also invested in plant improvements and technology. *Memorial Hospital* has just completed a renovation and expansion project of approximately $ 300 million. *Parkridge Health System*, an affiliate of *HCA Healthcare*, acquired another hospital in the region (*Grandview Hospital*) and recently completed relocation/expansion of its psychiatric facility with approximately $ 8 million invested. *Skyridge Medical Center*, in Bradley County is owned by *Community Health System*, consolidated two facilities and invested approximately $ 45 million in upgrades.

A large portion of the employees and families of the companies located in *Enterprise South Industrial Park* will be close to, and served by, *Erlanger East Hospital*.

Investment in the region is expected to continue across all industries for the foreseeable future. The Chattanooga Area Chamber of Commerce expects to meet its goal of adding more than 15,000 jobs by the end of 2015.

2. ***Access To Care***: **Every citizen should have reasonable access to care.**

Response

Erlanger is designated by *TennCare* as the safety net hospital, for underserved residents in southeast Tennessee. *Erlanger's* TennCare / Medicaid utilization and uncompensated care cost for the last three (3) fiscal years are presented below.

	TennCare / Medicaid Utilization %	Uncompensated Care Cost
FY 2012	29.1 %	$ 85.5 M
FY 2013	28.1 %	$ 85.1 M
FY 2014	29.4 %	$ 86.2 M

Notes
(1) TennCare / Medicaid utilization percentages are based on gross I/P charges derived from applicant's internal records.
(2) Uncompensated care cost estimates were derived from applicant's internal records as reported in the notes to the annual audited financial statements.
(3) Erlanger's fiscal year begins on July 1 of each year and ends on June 30 of the following year. For example, FY 2014 began on July 1, 2013, and ended on June 30, 2014.

Under the federal Medicare program, an urban hospital with more than 100 beds needs to serve only 15% of low-income patients in order to qualify as a "disproportionate share hospital". *Erlanger* clearly shoulders significantly more than its proportionate share of the care rendered to this patient population. The State Health Plan favors initiatives, like the project proposed herein, which help to foster access to the underserved.

Erlanger Medical Center has the only Level I trauma center, the only life-flight helicopter service, and the only children's hospital in the region. *Erlanger* is also the only provider in its service area of Level IV neonatal care and perinatal services.[1] *Erlanger Health System* is committed to maintaining its mission of providing healthcare services to all citizen's regardless of ability

1 Level IV as defined by the American College of Pediatrics; per the Tennessee licensure scheme it is a Level III neo-natal unit.

to pay. Such services include inpatient care, obstetrics, surgical and emergency care.

Erlanger Health System also operates several other hospitals in Southeast Tennessee, of which *Erlanger East Hospital* is a component facility, as well as a network of more than 40 practice sites and physician offices, as well as *Federally Qualified Health Centers* (hereinafter "FQHC"), so that patients may easily access needed services while also facilitating easy access to the broader healthcare delivery system.

3. ***Economic Efficiencies***: **The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system.**

Response

Historically, *EMC* has been very cost efficient within the context of the overall healthcare delivery system. The inpatient net revenue per admission for local competitors in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Net Revenue Per I/P Admission
Erlanger Medical Center	$ 10,579
Memorial Hospital	$ 10,968
Parkridge Medical Center	$ 15,503
Erlanger East Hospital	$ 5,271
Memorial Hospital - Hixson	$ 6,556
Parkridge East Hospital	$ 5,525

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2013.

To evidence this, with the initiation of the *Health Care Exchanges* on January 1, 2014; *Blue Network E* enrolled over 10,000 uninsured and *Erlanger* is the only provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S* and *Erlanger* is one of only two providers in this network as well. It is anticipated that these additional health networks will generate sufficient volume to keep *Erlanger* cost efficient.

While offering more complex services and capabilities, *Erlanger* has net revenue per inpatient admission lower than other large area hospitals. *Erlanger Medical Center* is economically efficient, while incurring higher costs by offering more complex services including the only Level I trauma center, the only life-flight helicopter service, the only children's hospital, and the only Level IV neonatal care in southeast Tennessee.[2]

4. ***Quality Of Care*: Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.**

Response

Erlanger Medical Center, which is accredited by *The Joint Commission*, participates in periodic submission of quality related data to the *Centers For Medicare & Medicaid Services* through its *Hospital Compare* program. *Erlanger East Hospital* is also accredited by *The Joint Commission*. Further, *EMC* and *EEH* has an internal program of *Medical Quality Improvement Committees* which continually monitor healthcare services to assure patients of the quality of care provided. The quality improvement program includes *Erlanger East Hospital*. Patients served at *Erlanger East Hospital* will have the same high quality care available at *Erlanger Medical Center*.

5. ***Health Care Workforce*: The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.**

Response

Erlanger Health System has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health

2 Level IV as defined by the American College of Pediatrics; per the Tennessee licensure scheme it is a Level III neo-natal unit.

areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at Erlanger and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Urology (beginning 2015)
- Transitional Year

Fellowship Programs

- Geriatrics
- Hospice & Palliative Care
- Orthopedic Surgery - Traumatology
- Surgical Critical Care
- Vascular Surgery
- Colon & Rectal Surgery
- Emergency Medicine
- Minimally Invasive Gynecologic Surgery
- Neuro-Interventional Surgery
- Ultrasound
- Cardiology (under development)
- Gastroenterology (under development)

Erlanger Health System also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

[End Of Responses To Principles Of Tennessee State Health Plan - 2011 Update, pages 5 - 13]

CARDIAC CATHETERIZATION SERVICES -- REVISED & UPDATED STANDARDS AND CRITERIA

[Standard & Criteria Effective November 18, 2009]

Standards For All Cardiac Catheterization Services

Applicants proposing to provide any type of cardiac catheterization services must meet the following minimum standards:

1.) Compliance With Standards: The Division Of Health Planning is working with stakeholders to develop a framework for greater accountability to these Standards and Criteria. Applicants should indicate whether they intend to collaborate with the Division and other stakeholders on this matter.

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, will fully collaborate with the Division of Health Planning and other stakeholders to develop a framework for greater accountability to these *Standards and Criteria*.

2.) Facility Accreditation: If the applicant is not required by law to be licensed by the Department of Health, the applicant should provide documentation that the facility is fully accredited or will pursue accreditation by the Joint Commission or another appropriate accrediting authority recognized by the Centers for Medicare and Medicaid Services (CMS).

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, is licensed by the Department of Health. Both facilities are accredited by *The Joint Commission*. Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

3.) Emergency Transfer Plan: applicants for cardiac catheterization services located in facility without open heart surgery capability should provide a formalized written protocol for immediate and

efficient transfer of patients to a nearby open heart surgical facility (within 60 minutes) that is reviewed / tested on a regular (quarterly) basis.

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, has a formalized written protocol for immediate and efficient transfer of patients to *Erlanger Medical Center*. A copy of the policy is attached to this CON application.

4.) **Quality Control & Monitoring: Applicants should document a plan to monitor the quality of its cardiac catheterization program, including, but not limited to, program outcomes and efficiency. In addition, the applicant should agree to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee, which may be developed per Policy Recommendation 2.**

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, has a plan to monitor the quality of its cardiac catheterization program, including but not limited to, program outcomes and efficiency. A copy of the policy is attached to this CON application. Applicant will cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee. Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

5.) **Data Requirements: Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.**

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, will provide to the *Department of Health* and/or the *Health Services & Development Agency* all reasonably requested information and statistical data. Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

6.) Clinical and Physical Environment Guidelines: Applicants should agree to document ongoing compliance with the latest clinical guidelines of the American College of Cardiology / Society For Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards (ACC Guidelines). As of the adoption of these Standards and Criteria, the latest version (2001) may be found online at: http://www.acc.org/qualityandscience/clinical/consensus/angioography/dirIndex.htm.

When providers are not in compliance, they should maintain appropriate documentation stating the reasons for noncompliance and the steps the provider is taking to ensure quality. These guidelines include, but are not limited to, physical facility requirements, staffing, training, quality assurance, patient safety, screening patients for appropriate settings, and linkages with supporting emergency services.

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, will document ongoing compliance with the latest clinical guidelines of the American College of Cardiology / Society For Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards (ACC Guidelines). Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

7.) Staffing Recruitment and Retention: The applicant should generally describe how it intends to maintain an adequate staff to operate the proposed service, including, but not limited to, any plans to partner with an existing provider for training and staff sharing.

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, will assign appropriate staff to the cardiac catheterization laboratory from the laboratory at *Erlanger Medical Center*. Since *Erlanger East Hospital*, is licensed and operates as, a satellite facility of *Erlanger Medical Center*, the staff located at *Erlanger East Hospital* will possess the same skills as the staff at *Erlanger Medical Center*. The skills of these staff members are transferable between both cardiac catheterization laboratories and they may be rotated between both locations. Such rotation will provide synergy for the cardiac catheterization service line within *Erlanger Health System*.

8.) Definition of Need For New Services: A need likely exists for new or additional cardiac catheterization services in a proposed service area if the average current utilization for all existing and approved providers is equal to or greater than 70% of capacity (i.e., 70% of 2000 cases) for the proposed service area.

Response

This criterion is not applicable because the cardiac catheterization laboratory at *Erlanger East Hospital* has already been approved (no. CN0405-047AE).

9.) Proposed Service Areas With No Existing Service: In proposed service areas where no existing cardiac catheterization service exists, the applicant must show the data and methodology used to estimate the need and demand for the service. Projected need and demand will be measured for applicants proposing to provide services to residents of those areas as follows:

Need. The projected need for a service will be demonstrated through need-based epidemiological evidence of the incidence and prevalence of conditions for which diagnostic and/or therapeutic catheterization is appropriate within the proposed

service area.

Demand. The projected demand for the service shall be determined by the following formula:

A. Multiply the age group-specific historical utilization rate by the number of residents in each age category for each county included in the proposed service area to produce the projected demand for each age category.

B. Add each age group's projected demand to determine the total projected demand for cardiac catheterization procedures for the entire proposed service area.

Response

This criterion is not applicable because the cardiac catheterization laboratory at *Erlanger East Hospital* has already been approved (no. CN0405-047AE).

10.) Access: In light of Rule 0720-4-.01(1), which lists the factors concerning need on which an application may be evaluated, the HSDA may decide to give special consideration to an applicant:

a.) Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration; or

Response

The zip codes which comprise the service area for *Erlanger East Hospital* are designated as medically underserved by the United States Health Resources and Services Administration.

b.) Who documents that the service area population experiences a prevalence, incidence and/or mortality from heart and cardiovascular diseases or other clinical conditions applicable to cardiac catheterization services that is

substantially higher than the State of Tennessee average; or

Response

The service area of *Erlanger East Hospital* is geographically smaller than Hamilton County, Tennessee, and the mortality data for heart disease from the Tennessee Dept. of Health does not provide less than county level with available data.

c.) Who is a "safety net hospital" as defined by the Bureau of Tenncare Essential Access Hospital payment program; or

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, is a component facility of the designated safety net hospital by the Bureau of Tenncare Essential Access Hospital payment program.

d.) Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program.

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, already has signed contracts with the Tenncare MCO's. Please see the list of contracts in section A of this CON application.

Specific Standards For Diagnostic Cardiac Catheterization Services Only

If an applicant does not intend to provide therapeutic cardiac catheterization services, the HSDA should place a condition on the resulting CON limiting the applicant to providing diagnostic cardiac catheterization services only. Applicants proposing to provide therapeutic cardiac catheterization services must meet the following minimum standards:

11.) Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 300 diagnostic cardiac catheterization cases per year by its third year of operation. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation. If the applicant is proposing services in a rural area where the HSDA determines that access to diagnostic cardiac catheterization services has been limited, and if the applicant is pursuing a partnership with a tertiary facility to share and train staff, the Agency may determine that a minimum volume of 200 cases per year is acceptable. Only cases including diagnostic cardiac catheterization procedures as defined by these Standards and Criteria may count towards meeting this minimum volume standard.

Response

This criterion is not applicable because *Erlanger East Hospital* is seeking approval to modernize its already approved, but not yet implemented, cardiac catheterization laboratory to perform therapeutic catheterization procedures.

12.) High Risk / Unstable Patients: Such applicants should (a) delineate the steps, based on the ACC Guidelines, that will be taken to ensure that high-risk or unstable patients are not catheterized in the facility, and (b) certify that therapeutic cardiac catheterization services will not be performed in the facility unless and until the applicant has received Certificate of Need approval to provide therapeutic cardiac catheterization services.

Response

High risk patients will not be catheterized at *Erlanger East Hospital*. A copy of the policy pertaining to selection of candidates for catheterization in the *Erlanger East Hospital* laboratory is attached to this CON application. Therapeutic catheterizations will not be performed in this laboratory until a CON has been approved.

13.) Minimum Physician Requirement To Initiate A New Service: The initiation of a new diagnostic cardiac cathetereization program should require at least one cardiologist who performed an average of 75 diagnostic cardiac catheterization procedures over the most recent five year period. All participating cardiologists in the proposed program should be board certified or board eligible in cardiology and any relevant cardiac subspecialties.

Response

Erlanger East Hospital is licensed, and currently operates as, a satellite facility of *Erlanger Medical Center*. While at *Erlanger Medical Center* or *Erlanger East Hospital*, the staff members may be rotated between both locations. Both hospitals are located within the same county. Such rotation will provide synergy and cross training for the cardiac catheterization service line within *Erlanger Health System*. As such, the cardiac catheterization service is not a new service. The cardiologists that practice within the cardiac catheterization service line have performed more than an average of 75 diagnostic catheterization procedures over the most recent 5 years.

Specific Standards For Therapeutic Cardiac Catheterization Services

Applicants proposing to provide therapeutic cardiac catheterization services must meet the following minimum standards:

14.) Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 400 diagnostic and/or therapeutic cardiac catheterization cases per year by its third year of operation. At least 75 of these cases per year should include a therapeutic cardiac catheterization procedure. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation. Only cases including diagnostic and therapeutic cardiac catheterization procedures as defined by these Standards and Criteria shall count towards meeting this minimum volume standard.

Response

The need for the cardiac catheterization service at *Erlanger East Hospital* will meet the minimum volume standard. Following is the estimated volume of low risk interventional catheterization patients at *Erlanger East Hospital*.

	Interventional Patients	Total Patients
Year 1	127	509
Year 2	132	527

The skills of the staff members at *Erlanger Medical Center* are transferable between both cardiac catheterization laboratories and constitute a core competency of *Erlanger Health System*. While at *Erlanger Medical Center* or *Erlanger East Hospital*, these staff members may be rotated between both locations. Both hospitals are located within the same county. Such rotation will provide synergy for the cardiac catheterization service line within *Erlanger Health System*.

It should be noted that the original CON in 2004 was approved based on the 2000 *Standards And Criteria* and this was updated by the *Standards And Criteria* which were adopted in 2009. The state of current clinical practice has progressed beyond this point. See the article attached to this CON application from the New England Journal of Medicine which reports on the CPORT Trials and essentially concludes that there is no difference in the care provided at facilities which do not have cardiac surgery. Further, the ACC / AHA recommendations are that Percutaneous Coronary Intervention is reasonable in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished.

15.) Open Heart Surgery Availability: Acute care facilities proposing to offer adult therapeutic cardiac catheterization services shall not be required to maintain an on-site open heart surgery program. Applicants without on-site open heart surgery should follow the most recent American College of Cardiology / American Heart Association / Society For Cardiac Angiography and Interventions Practice Guideline

Update for Percutaneous Coronary Intervention (ACC/AHA/SCAI Guidelines). As of the adoption of these Standards and Criteria, the latest version (2007) may be found online at: http://www.ahajournals.org/cgi/CIRCULATIONAHA.107.185159.

Therapeutic procedures should not be performed in free standing cardiac catheterization laboratories, whether fixed or mobile. Mobile units may, however, perform therapeutic procedures provided the mobile unit is located on a hospital campus and the hospital has on-site open heart surgery. In addition, hospitals approved to perform therapeutic cardiac catheterizations without on-site open heart surgery backup may temporarily perform these procedures in a mobile laboratory on the hositpal's campus during construction impacting the fixed laboratories.

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, follows the most recent American College of Cardiology / American Heart Association / Society For Cardiac Angiography and Interventions Practice Guideline Update for Percutaneous Coronary Intervention (ACC/AHA/SCAI Guidelines).

16.) Minimum Physician Requirement To Initiate A New Service: The initiation of a new therapeutic cardiac catheterization program should require at least two cardiologists with at least one cardiologist who performed an average of 75 therapeutic procedures over the most recent five year period. All participating cardiologists in the proposed program should be board certified or board eligible in cardiology and any relevant cardiac subspecialties.

Response

Erlanger East Hospital, as a satellite hospital of *Erlanger Medical Center*, will have a minimum of 2 cardiologists with at least 1 cardiologist who performed an average of 75 therapeutic procedures over the most recent five year period.

17.) Staff and Service Availability: Ideally, therapeutic services should be available on an emergency basis 24 hours per day, 7 days per week through a staff call schedule (24/7 emergency coverage). In addition, all laboratory staff should be available within 30 minutes of the activation of the laboratory. If the applicant will not be able to immediately provide 24/7 emergency coverage within three years of initiating the service or present a signed transfer agreement with another facility capable of of treating transferred patients in a cardiac catheterization laboratory on a 24/7 basis within 90 minutes of the patient's arrival at the originating emergency department.

Response

The cardiac catheterization patients which are served at *Erlanger East Hospital* will be low risk patients. High risk patients will be served at *Erlanger Medical Center*. The skills of the staff members at *Erlanger Medical Center* are transferable between both cardiac catheterization laboratories and constitute a core competency of *Erlanger Health System*. While at *Erlanger Medical Center* or *Erlanger East Hospital*, these staff members may be rotated between both locations. Both hospitals are located within the same county. Such rotation will provide synergy for the cardiac catheterization service line within *Erlanger Health System*.

The cardiac catheterization laboratory at *Erlanger Medical Center* comports with the standards in this criterion.

18.) Expansion Of services To Include Therapeutic Cardiac Catheterization: An applicant proposing the establishment of therapeutic cardiac catheterization services, who is already an existing provider of diagnostic catheterization services, should demonstrate that its diagnostic cardiac catheterization unit has been utilized for an average minimum of 300 cases per year for the two most recent years as reflected in the data supplied to and/or verified by the Department of Health.

Response

Erlanger East Hospital, is currently in the process of implementing its cardiac catheterization laboratory. However, the cardiac catheterization laboratories at *Erlanger Medical Center* perform the minimum number of 300 diagnostic catheterizations per year for each of the 2 most recent years reflected in the data supplied to the Department of Health. The skills of the staff members at *Erlanger Medical Center* are transferable between both cardiac catheterization laboratories and constitute a core competency of *Erlanger Health System*. While at *Erlanger Medical Center* or *Erlanger East Hospital*, these staff members may be rotated between both locations. Both hospitals are located within the same county. Such rotation will provide synergy for the cardiac catheterization service line within *Erlanger Health System*.

Specific Standards For Pediatric Cardiac Catheterization Services

Applicants proposing to provide pediatric cardiac catheterization services should meet the following minimum standards:

19.) Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 100 cases per year by its third year of operation. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation. Only cases that include diagnostic and therapeutic cardiac catheterization procedures as defined by these Standards and Criteria shall count towards meeting this minimum volume standard.

Response

This is not applicable because *Erlanger East Hospital* will not be performing pediatric cardiac catheterization procedures.

20.) Minimum Physician Requirements to Initiate a New Service: The initiation of a new pediatric cardiac catheterization program should require at least two cardiologists with at least one cardiologist having

performed an average of 50 pediatric cardiac catheterization procedures over the most recent five year period. Pediatric cardiac catheterization procedures should be performed only by board certified or board elgible physicians specializing in pediatric cardiac care.

Response

This is not applicable because *Erlanger East Hospital* will not be performing pediatric cardiac catheterization procedures.

21.) Open heart Surgery Availability: Such applicants should offer full pediatric cardiac medical and surgical capabilities, including pediatric open heart surgery.

Response

This is not applicable because *Erlanger East Hospital* will not be performing pediatric cardiac catheterization procedures.

Specific Standards For Mobile Cardiac Catheterization Services

The need for mobile cardiac catheterization services should be based upon the following minimum standards:

22.) Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 60 cardiac catheterization cases per day of operation per year by its third year of operation. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation. If the applicant is proposing services in a rural area where the HSDA determines that access to diagnostic cardiac catheterization services has been limited, and if the applicant is pursuing a partnership with a tertiary facility to share and train staff, the Agency may determine that a minimum volume of 40 cases per day of operation per year is acceptable. Only cases that include diagnostic cardiac catheterization

procedures may count towards meeting this minimum volume standard.

Response

This is not applicable because *Erlanger East Hospital* will not be offering mobile cardiac catheterization procedures.

23.) Limitations On Procedure Types in Mobile Facilities: No therapeutic or pediatric cardiac catheterization procedures should be performed using a mobile laboratory unless the mobile unit is located on a hospital campus with on-site open heart surgery capability and, in the case of a pediatric procedure, offers full pediatric cardiac medical and cardiac surgical capabilities. On a temporary basis, however, the same scope of services offered in a fixed laboratory may be offered in a mobile laboratory only for the duration of construction impacting the fixed laboratory.

Response

This is not applicable because *Erlanger East Hospital* will not be offering mobile cardiac catheterization procedures.

[End Of Responses To Standard & Criteria For Cardiac Catheterization Services, Effective November 18, 2009, pages 7 - 24]

GENERAL QUESTIONS CONCERNING NEED, ECONOMIC FEASIBILITY & CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

(I.) *NEED*

1. Describe the relationship of this proposal toward the implementation of the State Health Plan, Teneessee's Health: Guidelines For Growth.

(a) Please provide a response to each criterion and standard in Certificate Of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

Response

This project is consistent with the *Principles Of The Tennessee State Health Plan* as stated in the 2011 update ("Principles"). *Applicant* has addressed each of the Principles.

(b) Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).

Response

** Not applicable. **

2. Describe the relationship of this proposal to the applicant facility's long range development plans, if any.

Response

Erlanger Health System currently holds a CON for expansion of *Erlanger East Hospital* (No. CN0405-047AE); and a CON to modernize and upgrade the surgical facilities at *Erlanger Medical Center* (No. CN1207-034A).

As part of the long range development plan for *Erlanger East Hospital*, the HSDA approved an extension of the CON (CN0405-047AE) on September 24, 2014, for the transfer of up to 70 additional beds from *Erlanger Medical Center*. The expansion of *Erlanger East Hospital* is in process.

Given the time span since original approval, *Erlanger East Hospital* has a need, and seeks approval, to modernize its facility plan for this final phase of the expansion project. In a similar fashion, a CON application was submitted in December, 2014, for *Erlanger East Hospital* seeking approval to initiate a satellite radiation therapy

service along with the relocation of a Linear Accelerator from *Erlanger Medical Center* (no. CN1412-048). Additional initiatives are being evaluated that may require further review in coming months for additional "*change of scope*" services.

The goal for *Erlanger Health System* is to provide a comprehensive system of care comprised of unduplicated services while also serving those who are currently under served and/or those who do not have the ability to pay for their services. The upgrade of the Cardiac Catheterization Laboratory at *Erlanger East Hospital* is part of our long term plan to make services more accessible.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit maps on 8 ½" x 11" sheets of white paper marked only with ink detectable by a standard photocopier (i.e-no highlighters, pencils, etc.).

Response

The service area for *Erlanger East Hospital* is defined as the following ten (10) zip codes.

30736	Ringgold, GA
30742	Fort Oglethorpe, GA
37302	Apison, TN
37341	Harrison, TN
37353	McDonald, TN
37363	Ooltewah, TN
37411	Chattanooga, TN
37412	East Ridge, TN
37416	Chattanooga, TN
37421	Chattanooga, TN

These zip codes comprise East Hamilton County and West Bradley County in Tennessee, along with 2 zip codes from Catoosa County in Georgia.

4. A. Describe the demographics of the population to be served by this proposal.

Response

The service area of the applicant is defined above. Following is a discussion of certain population trends.

Estimated Population - Age Group 65 +

	Est. Pop. 2015	Est. Pop. 2020	Growth Rate
Erlanger East Svc. Area	33,102	38,699	16.9%
Hamilton county, TN	127,414	147,362	15.5%

Notes
(1) 2015 and 2020 population figures based on original data from *Claritas* and projected forward by EHS.

The population that will primarily utilize cardiac catheterization services is the age group 65 and over. As may be seen from the population data above, this group is expected to grow faster for the *Erlanger East* service area (16.9%) compared to the growth rate for Hamilton County, Tennessee (15.5%). It is also likely that other age groups will be served along with those age 65 and over that are low risk.

Further, a summary of other demographic information appears below which outlines TennCare enrollment and population below the Federal poverty level by county within the service area compared to the State of Tennessee.

	Hamilton	Bradley
Total Pop. - 2014	347,451	103,308
Total Pop. - 2018	353,577	107,481
Total Pop. - % Change	1.8%	4.0%
Median Age	38	38
Median Household Income	$46,544	$40,614
TennCare Enrollees	57,298	18,850
TennCare Enrollees As % Of Total Pop.	16.5%	18.2%
Persons Below Poverty Level	56,287	18,389
Persons Below Poverty Level As % Of Total Pop.	16.2%	17.8%

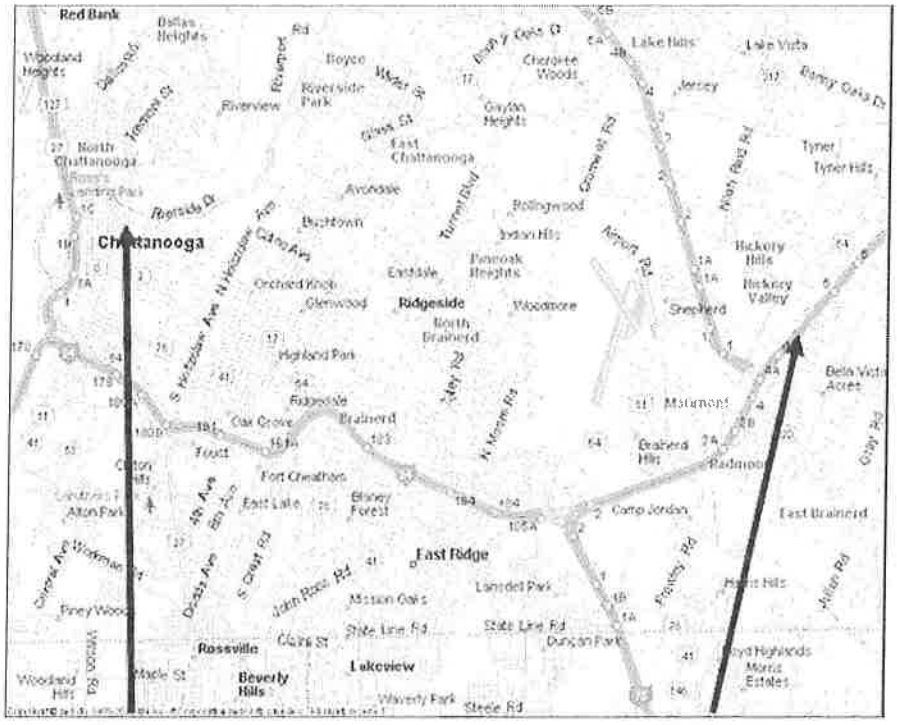
B. The special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women,

racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response

As a member facility of *Erlanger Health System*, *Erlanger East Hospital* is a component of the safety net for southeast Tennessee. Often the only hospital which low-income people, minorities, and other underserved populations can turn to for treatment is *Erlanger*. In order to assure the continued viability of its mission as the safety net provider, *Erlanger Health System* continually strives to provide services that are medically appropriate, least intensive (restrictive), and provided in the most cost-effective health care setting.

Erlanger East Hospital is accessible to patients in Chattanooga and Hamilton County from both primary and secondary roads. Additionally, the hospital can be easily accessed via public transportation. Further, proximal state and interstate highways provide easy access from Tennessee, Georgia and Alabama.



It is estimated that the population age 65 and over in the *Erlanger East* service area will increase from 33,102 in 2015 to 38,699 in 2020. This is an increase of 16.9%. Thus, the project envisioned by the instant application is intended to be of direct benefit to the senior population, which is primarily the group that will utilize cardiac catheterization services.

Erlanger has also been responsive to the needs of employees and families of new businesses like VW, Amazon and Wacker Chemical which have generated thousands of new jobs in the area. The proposed project will help ensure that the service area population have access to services and facilities consistent with their needs and evolving industry standards.

5. Describe the existing or certified services, including approved but unimplemented CON's, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utlilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response

There are no other cardiac catheterization laboratories in the *Erlanger East* service are. All of the cardiac catheterization laboratories currently in Hamilton County, Tennessee, are clustered within 2 miles of each other; at *Erlanger Medical Center*, *Memorial Hospital* and *Parkridge Medical Center*. These facilities are located approximately 9 miles, or more, from *Erlanger East Hospital*, or about 20-25 minutes travel time.

Utilization data for the three (3) acute care hospitals in Chattanooga, Tennessee, is presented below.

Community Hospitals -- Chattanooga, Tennessee General Utilization Trends									
	2011			2012			2013		
	Erlanger East	Memorial Hixson	Parkridge East	Erlanger East	Memorial Hixson	Parkridge East	Erlanger East	Memorial Hixson	Parkridge East
General Acute Care - Admissions	4,632	4,099	4,977	4,909	4,194	5,393	4,803	4,088	5,487
Inpatient Pt. Days - Acute Care	9,766	16,622	16,472	10,382	16,982	19,103	10,278	16,617	20,617
General Acute Care - ALOS	2.11	4.06	3.31	2.11	4.05	3.54	2.14	4.06	3.76
ED Visits	0	30,156	36,144	0	30,636	42,033	6,100	25,516	38,136
Total Surgical Patients	8,065	4,010	4,229	8,576	4,056	4,253	8,407	3,923	4,104
OB Deliveries	2,466	0	2,896	2,607	0	3,154	2,531	0	3,128

NOTES

(1) This information is derived from *Tennessee Joint Annual Reports*.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response

Utilization data for *Erlanger East Hospital* is presented below.

Erlanger East hospital General Utilization Trends								
				Projected Utilization				
	2012	2013	2014	2015	2016	2017	2018	2019
General Acute Care - Admissions	2,840	2,709	2,640	2,770	2,791	2,811	2,832	2,853
Inpatient Pt. Days - Acute Care	6,406	6,161	5,690	6,185	6,231	6,277	6,323	6,370
General Acute Care - ALOS	2.26	2.27	2.16	2.23	2.23	2.23	2.23	2.23
ED Visits	0	6,100	22,008	24,748	25,367	26,001	26,651	27,317
Total Surgical Patients	3,182	3,183	3,262	3,188	3,212	3,236	3,260	3,284
OB Deliveries	2,619	2,553	2,508	2,592	2,611	2,631	2,650	2,669

NOTES

(1) This information is derived from the internal records of *Erlanger Health System*.

(2) The trends outlined are based on historical trends. Upon completion of the expansion project at *Erlanger East Hospital* (no. CN0407-047), utilization will be higher.

The projected utilization is based upon a use rate average calculation for the three (3) year period of 2012,

2013 and 2014. Expected growth could exceed this forecast based on hospital referral patterns, health reform initiatives and/or advances in clinical care. Further, the expansion project for *Erlanger East Hospital* will result in additional growth when that project is completed.

(II.) *ECONOMIC FEASIBILITY*

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**

   - **All projects should have a project cost of at least $ 3,000 on Line F (minimum CON filing fee). CON filing fee should be calculated from Line D. (See application instructions for filing fee.)**

   - **The cost of any lease should be based on fair market value or the total amount of lease payments over the initial term of the lease, whichever is greater.**

   - **The cost of fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

   - **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

Response

The *Project Cost Chart* has been completed on the next page.

PROJECT COST CHART

A.	Construction And Equipment Acquired By Purchase.	
1.	Architecural And Engineering Fees	
2.	Legal, Administrative, Consultant Fees (Excluding CON Filing Fees)	
3.	Acquisition Of Site	
4.	Preparation Of Site	
5.	Construction Costs	
6.	Contingency Fund	
7.	Fixed Equipment (Not Included In Construction Contract)	
8.	Moveable Equipment (List all equipment over $ 50,000)	300,000
9.	Other (Specify) Technical, Signage, Environmental, etc.	
B.	Acquisition By Gift, Donation, Or Lease.	
1.	Facility (inclusive of building and land)	
2.	Building Only	
3.	Land Only	
4.	Equipment (Specify)	
5.	Other (Specify)	
C.	Financing Costs And Fees.	
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve For One Year's Debt Service	
4.	Other (Specify)	
D.	Estimated Project Cost (A + B + C)	300,000
E.	CON Filing Fee	3,000
F.	Total Estimated Project Cost (D + E)	303,000

2. Identify the funding sources for this project.

a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

___ A. Commercial Loan -- Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

___ B. Tax - Exempt Bonds -- Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

___ C. General obligation bonds -- Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants -- Notification of intent form for grant application or notice of grant award.

___ E. Cash Reserves - Appropriate documentation from Chief Financial Officer.

_X_ F. Other - Identify and document funding from all other sources.

Response

The project will be funded by continuing operations of *Erlanger Health System*. The CFO letter is attached to this CON application.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services And Development Agency.

Response

The cardiac catheterization service at *Erlanger East Hospital* has already been approved (no. CN0405-047AE). The project cost is estimated to be $ 303,000. This cost is intended to cover miscellaneous equipment necessary to update the laboratory consistent with current standards.

4. Complete Historical and Projected Data Charts on the following two pages - *Do not modify the Charts provided or submit Chart substitutions* ! Historical Data Chart represents revenue and expense information for the last *three* (3) years for which complete information is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (i.e.-if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response

The *Historical Data Chart* and *Projected Data Chart* have been completed. The detail for *Other Expenses* on the *Historical Data Chart* is attached to this CON application.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		Year – 2012	Year – 2013	Year – 2014
A.	Utilization Data	28,773	28,840	30,098
	(Specify Unit Of Measure) I/P Admits			
B.	Revenue From Services To Patients			
	1. Inpatient Services	971,094,413	951,407,744	1,011,698,242
	2. Outpatient Services	600,067,032	638,832,332	723,658,840
	3. Emergency Services	112,850,427	122,125,184	147,183,286
	4. Other Operating Revenue	37,187,604	33,499,831	36,036,026
	(Specify) Home Health, POB Rent, etc.			
	Gross Operating Revenue	1,721,199,476	1,745,865,091	1,918,576,394
C.	Deductions From Operating Revenue			
	1. Contractual Adjustments	980,425,997	997,920,752	1,105,607,716
	2. Provision For Charity Care	78,323,761	102,150,881	110,213,778
	3. Provision For Bad Debt	99,422,380	74,808,470	84,222,955
	Total Deductions	1,158,172,138	1,174,880,103	1,300,044,449
	NET OPERATING REVENUE	563,027,338	570,984,988	618,531,945
D.	Operating Expenses			
	1. Salaries And Wages	277,849,780	275,109,764	276,229,682
	2. Physician's Salaries And Wages	35,148,510	36,117,461	42,290,749
	3. Supplies	79,185,467	78,028,042	82,925,430
	4. Taxes	553,433	536,994	566,101
	5. Depreciation	26,569,378	27,373,556	26,732,222
	6. Rent	3,632,579	5,341,116	5,209,326
	7. Interest – Other Than Capital	0	0	0
	8. Management Fees:			
	a. Fees To Affiliates			
	b. Fees To Non-Affiliates			
	9. Other Expenses	149,478,971	156,440,656	166,565,645
	(Specify) Insurance, Purch. Svcs., etc.			
	Total Operating Expenses	572,418,118	578,947,589	600,519,155
E.	Other Revenue (Expenses) - Net			
	(Specify)			
	NET OPERATING INCOME (LOSS)	(9,390,780)	(7,962,601)	18,012,789
F.	Capital Expenditures			
	1. Retirement Of Principal	7,396,156	7,900,842	8,048,272
	2. Interest	9,652,060	8,971,728	8,258,717
	Total Capital Expenditures	17,048,216	16,872,570	16,306,989
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	(26,438,996)	(24,835,171)	1,705,800

PROJECTED DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in ___July___ (Month).

		Year 1	Year 2
A.	Utilization Data	127	132
	(Specify Unit Of Measure) Interventional Cath. Proc's		
B.	Revenue From Services To Patients		
	1. Inpatient Services		
	2. Outpatient Services	4,443,678	4,909,334
	3. Emergency Services		
	4. Other Operating Revenue		
	Gross Operating Revenue	4,443,678	4,909,334
C.	Deductions From Operating Revenue		
	1. Contractual Adjustments	2,822,238	3,175,074
	2. Provision For Charity Care	166,014	186,769
	3. Provision For Bad Debt	332,028	373,538
	Total Deductions	3,320,280	3,735,381
	NET OPERATING REVENUE	1,123,398	1,173,953
D.	Operating Expenses		
	1. Salaries And Wages	250,052	260,805
	2. Physician's Salaries And Wages		
	3. Supplies	552,456	603,559
	4. Taxes		
	5. Depreciation	30,000	30,000
	6. Rent		
	7. Interest - Other Than Capital		
	8. Management Fees:		
	a. Fees To Affiliates		
	b. Fees To Non-Affiliates		
	9. Other Expenses	75,449	85,071
	(Specify) Service Contracts		
	Total Operating Expenses	907,958	979,434
E.	Other Revenue (Expenses) – Net		
	(Specify) _____		
	NET OPERATING INCOME (LOSS)	215,440	194,518
F.	Capital Expenditures		
	1. Retirement Of Principal		
	2. Interest		
	Total Capital Expenditures		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	215,440	194,518

5. **Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.**

Response

Following are the average charge amounts per patient.

Average Gross Charge	$ 34,990
Average Deduction From Revenue	$ 26,144
Average Net Revenue	$ 8,846
Average Deduction From Revenue	
Medicare	$ 24,770
TennCare / Medicaid	$ 25,909
Average Net Revenue	
Medicare	$ 9,576
TennCare / Medicaid	$ 3,675

6. A. **Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges of projects that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.**

Response

Please see the list of average patient charges by service line for *Erlanger East Hospital* and similar hospitals in Hamilton County, Tennessee, for the calendar year 2013, attached to this CON application. Applicant does revise it's patient charge structure on a periodic basis (i.e.- usually annually) during the budget cycle each fiscal year. However, applicant does not anticipate any changes to existing patient charges specifically as a result of this project.

B. **Compare the proposed charges to those of other facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services And Development Agency. If applicable, compare the**

proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response

Please see the list of average patient charges by service line for *Erlanger East Hospital* and similar hospitals in Hamilton County, Tennessee, for the calendar year 2013, attached to this CON application. The average patient charge for each hospital is as follows.

Erlanger East	$ 9,085
Memorial Hospital - Hixson	$ 25,131
Parkridge East Hospital	$ 29,292

7. Discuss how projected utilization rates will be sufficient to maintain cost effectiveness.

Response

Historically, *Erlanger East Hospital* has been very cost efficient within the context of the overall healthcare delivery system. The inpatient net revenue per admission for similar hospitals in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Net Revenue Per I/P Admission
Erlanger East Hospital	$ 5,271
Memorial Hospital - Hixson	$ 6,556
Parkridge East Hospital	$ 5,525

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2013.

8. Discuss how financial viability will be ensured within two (2) years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response

As demonstrated by the *Projected Data Chart*, the project is financially viable in both years 1 and 2.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response

Erlanger East Hospital, as a member facility of *Erlanger Health System*, currently participates in the following Federal / State programs.

Federal	Medicare
State	BlueCare TennCare Select AmeriGroup Community Care

Anticipated revenue (gross charges) from Federal and State sources during year 1 of the project, is as follows.

Medicare	$ 526,694
TennCare	$ 25,727
	$ 552,420

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response

Copies of the following financial statements for *Erlanger Health System* are attached to this CON application.

Interim Balance Sheet & Income Statement	Dec. 31, 2014
Audited Financial Statements	June 30, 2014

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to,

A. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If developments of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response

As the demographic data presented earlier in this CON application demonstrates, the population over age 65 in the Erlanger East service area is growing at a rate faster than that for Hamilton County, Tennessee.

Estimated Population - Age Group 65 +

	Est. Pop. 2015	Est. Pop. 2020	Growth Rate
Erlanger East Svc. Area	33,102	38,699	16.9%
Hamilton county, TN	127,414	147,362	15.5%

Notes
(1) 2015 and 2020 population figures based on original data from *Claritas* and projected forward by EHS.

Modernization of the cardiac catheterization service for *Erlanger East Hospital* reflects changes in accepted practice and patient safety since the original CON was approved. Additionally, improved patient access to this needed service will result which is preferable to the cluster of catheterization laboratories in the downtown Chattanooga area.

In light of this information, the best alternative for Erlanger Health System is simply to upgrade the catheterization laboratory that has already been approved at *Erlanger East Hospital*. The only other option is to expand the catheterization laboratory at *Erlanger Medical Center*, which is not considered to be a viable option.

As *the* safety net hospital in Southeast Tennessee, it is vital that *Erlanger Health System* enhance and update its facilities to provide the best and most accessible services available for the communities we serve. As an academic medical center affiliated with the University of Tennessee College of Medicine, which is co-located on the *Erlanger Medical Center* campus, *EHS* also seeks to provide appropriate facilities so as to enhance the training and education of medical residents and fellows as well as other health professionals. Updating facilities also means planning for tomorrow with regard for the regional service area, ensuring that the needs of the uninsured and/or low income population are being met.

B. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response

As the demographic data presented earlier in this CON application demonstrates, the population over age 65 in the Erlanger East service area is growing at a rate faster than that for Hamilton County, Tennessee.

Estimated Population – Age Group 65 +

	Est. Pop. 2015	Est. Pop. 2020	Growth Rate
Erlanger East Svc. Area	33,102	38,699	16.9%
Hamilton county, TN	127,414	147,362	15.5%

Notes
(1) 2015 and 2020 population figures based on original data

from *Claritas* and projected forward by EHS.

The demographic data also shows that this growth rate is significantly higher than the total population growth rate of 1.8% for Hamilton County.

Modernization of the cardiac catheterization service for *Erlanger East Hospital* reflects changes in accepted practice and patient safety since the original CON was approved. The only other option is to expand the catheterization laboratory at *Erlanger Medical Center*, which would be more expensive than simply upgrading the laboratory at *Erlanger East Hospital*. Additionally, the vulnerable population of East Hamilton County would not have improved access to this needed service. For these reasons, this is truly the "low cost" option for *Erlanger Health System*.

As *the* safety net hospital in Southeast Tennessee, it is vital that *Erlanger Health System* enhance and update its facilities to provide the best and most services available for the communities we serve. As an academic medical center affiliated with the University of Tennessee College of Medicine, which is co-located on the *Erlanger Medical Center* campus, *EHS* also seeks to provide appropriate facilities so as to enhance the training and education of medical residents and fellows as well as other health professionals. Updating facilities also means planning for tomorrow with regard for the regional service area, ensuring that the needs of the uninsured and/or low income population are being met.

(III.) *CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE*

1. **List all health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

   Response

The most significant relationship between this proposal and the existing healthcare system is that it will be part of an existing health system and enhance *Erlanger's* ability to integrate its services within the regional service area as the safety net provider, trauma center and region's only academic medical center.

By providing these services regardless of a patient's ability to pay, the regional healthcare delivery system is positively impacted by the services envisioned in the instant application. Further, it provides better access to the cardiac catheterization service for patients that may otherwise have difficulty obtaining such services.

The applicant currently has transfer arrangements with the following hospitals which are owned by *Erlanger Health System*.

-- Erlanger Medical Center
-- Erlanger North Hospital
-- T. C. Thompson Children's Hospital
-- Erlanger Bledsoe Hospital

Further, Erlanger currently has patient transfer agreements in place with more than 60 hospitals and other providers in the four (4) state area. These providers refer patients to *Erlanger* because of the depth and breadth of its programs and services. A copy of the list of transfer agreements is attached to this CON application.

2. Describe the positive and / or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response

The effects of this proposal will be positive for the healthcare system because it will deliver the most appropriate level of care for those who are in need of service regardless of ability to pay, and will also distribute needed services across the service area to foster improved patient access. By providing this cardiac

catheterization service, the regional healthcare delivery system is positively impacted by serving as the "safety net" for those who are otherwise in need of this highly specialized service.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTE's for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the *Tennessee Dept. Of Labor & Workforce Development* and/or other documented sources.

Response

Clinical staffing for the satellite cardiac catheterization laboratory at *Erlanger East Hospital* is anticipated to be 4 Cardiovascular Specialists. Appropriate salary comparison data is below.

Position	EHS Avg.	Market Mid-Point
Cardiovascular Spec.	$ 26.34	$ 24.03

NOTES
(1) EHS data is derived from the internal records of *Erlanger Health System*.
(2) The market mid-point is derived from the 2014 Hay Group Salary Survey.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response

Since this project will involve the rotation of cardiac catheterization staff members from *Erlanger Medical Center*, it is not anticipated that any additional personnel will be needed. Due to cross training the skills of these staff members are transferable between locations and considered to be part of their core competency.

However, if it is necessary to recruit personnel for this project, the human resources required will be approached with a proactive recruitment action plan. Historically, *Erlanger* has met staffing requirements by utilizing a variety of methods. Thus, our approach to fulfill the staffing plan will consist of a proactive plan of marketing, screening, hiring, and training.

The Human Resources Department at *Erlanger* will work closely with managers in the transition. The specifics will be based on the needs of the organization and aligned with the strategic initiative of *Erlanger East Hospital*. *Erlanger* has actively been involved in the WorkForce Development movement on several different levels within the Chattanooga area and statewide. Current vacancy rates are below state and national averages.

Erlanger Health System participates with numerous schools that provide advanced training in the areas of nursing and allied health. Therefore, *Erlanger* expects no difficulty in recruitment of required staff given it's role as an academic medical center and it's affiliations with colleges and universities offering allied health and related training programs.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education*.

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy and surgery technology, to name a few.

A number of regional universities offer Bachelor degree programs in nursing and physical therapy. *Erlanger* works closely with the University of Tennessee at Chattanooga to assist nurses transitioning from RN to BSN. Erlanger provides a teaching environment for staff as well with various on-the-job training opportunities (ex: CT for Radiologic Technologist, Certification for LPNs). Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine, Diagnostic Ultrasonography, etc. *Erlanger Health System* participates with numerous schools that provide advanced training in the areas of nursing and allied health.

Erlanger has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at *Erlanger* and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

Emergency Medicine
Family Medicine

Internal Medicine
Obstetrics & Gynecology
Orthopedic Surgery
Pediatrics
Plastic Surgery
Surgery
Urology (beginning 2015)
Transitional Year

Fellowship Programs

Geriatrics
Hospice & Palliative Care
Orthopedic Surgery - Traumatology
Surgical Critical Care
Vascular Surgery
Colon & Rectal Surgery
Emergency Medicine
Minimally Invasive Gynecologic Surgery
Neuro-Interventional Surgery
Ultrasound
Cardiology (under development)
Gastroenterology (under development)

Erlanger Health System participates with numerous schools that provide advanced training in the areas of nursing and allied health.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations. Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and / or accreditation.

Licensure: State of Tennessee, Dept. of Health

Accreditation: The Joint Commission

If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency or commission. Provide a copy of the current license of the facility.

Response

Erlanger East Hospital, as a satellite facility of *Erlanger Medical Center*, continuously strives to comply with applicable regulations and make needed changes where deficiencies may arise to ensure full compliance. A copy of the current license from the Tennessee Dept. of Health is attached to this CON application. Further, a copy of the most recent *Letter Of Accreditation* from *The Joint Commission* is attached to this CON application. Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

(c) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response

A copy of the most recent licensure/certification inspection report with an approved plan of correction is attached to this CON application.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5 % ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Response

This criterion is not applicable because *Erlanger East Hospital*, as a satellite facility of *Erlanger Medical Center*, operates as part of the Chattanooga-Hamilton County Hospital Authority, which is a governmental unit and a statutory entity under the State of Tennessee. As such, it is not possible for there to be any "owners", per se, except for the people of Hamilton County, Tennessee, and the State of Tennessee.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5 % ownership interest in the project.

Response

This criterion is not applicable because *Erlanger East Hospital*, as a satellite facility of *Erlanger Medical Center*, operates as part of the Chattanooga-Hamilton County Hospital Authority, which is a governmental unit and a statutory entity under the State of Tennessee. As such, it is not possible for there to be any "owners", per se, except for the people of Hamilton County, Tennessee, and the State of Tennessee.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services And Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

Response

Applicant will provide the *Health Services And Development Agency* with appropriate information in consideration of this CON application.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of publication of the letter of intent.

Attached is a copy of the *Letter Of Intent* which was filed with the *Tennessee Health Services & Development Agency* on February 10, 2015. The original *Affidavit Of Publication* is also attached to this CON application.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for cause shown. Subsequent to granting a Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   Response

   The *Project Completion Forecast Chart* has been completed and appears on the following page.

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Response

   *** Not Applicable. ***

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c): May. 27, 2015

Assuming the CON approval becomes the final Agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE		Days Required	Anticipated Date (MONTH / YEAR)
1.	Architectural and engineering contract signed.		
2.	Construction documents approved by the *Tennessee Dept. Of Health.*		
3.	Construction contract signed.		
4.	Building permit secured.		
5.	Site preparation completed.		
6.	Building construction commenced.		
7.	Construction 40 % complete.		
8.	Construction 80 % complete.		
9.	Construction 100 % complete (approved for occupancy).		
10.	*Issuance of license.		04 / 2016
11.	*Initiation of service.		04 / 2016
12.	Final Architectural Certification Of Payment.		
13.	Final Project Report Form (HF0055).		

(*) For projects that do NOT involve construction or renovation, please complete items 10 and 11 only.

NOTE – If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

A F F I D A V I T

STATE OF TENNESSEE

COUNTY OF HAMILTON

Joseph M. Winick, being first duly sworn, says that he / she is the applicant named in this application or his / her / it's lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Agency Rules, and T.C.A. § 68-11-1601, *et seq*, and that the responses to this application or any other questions deemed appropriate by the Tennessee Health Services & Development Agency are true and complete.

SIGNATURE

SWORN to and subscribed before me this 10 of February (Month), 2015 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

SHELIA HALL STATE OF TENNESSEE NOTARY PUBLIC HAMILTON COUNTY

Sheila Hall

NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

TABLE OF ATTACHMENTS

** NOTE - The attachments are paginated and the page number begins with "A". The page number appears in the upper right hand corner of the page.

ATTACHMENTS

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before February 10, 2015, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger East Hospital, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to modernize the CON originally issued in 2004 (no. CN0405-047AE) by upgrading the Cardiac Catheterization Lab to perform interventional cardiac procedures from the already approved diagnostic cardiac procedures at Erlanger East Hospital. If approved, the number of approved cardiac catheterization labs in the service area will remain the same. The expansion of Erlanger East Hospital (CON No. CN0405-047AE) is in process. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger East Hospital, 1755 Gunbarrel Road, Chattanooga, Hamilton County, Tennessee, 37421. The total project cost is estimated to be $ 303,000.00.

The anticipated date of filing the application is February 13, 2015.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	February 5, 2015	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

LEGAL NOTICES LEGAL NOTICES LEGAL NOTICES

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et. seq., and the Rules of the Health Services & Development Agency, that Erlanger East Hospital, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to modernize the CON originally issued in 2004 (no. CN0405-047AE) by upgrading the Cardiac Catheterization Lab to perform interventional cardiac procedures from the already approved diagnostic cardiac procedures at Erlanger East Hospital. If approved, the number of approved cardiac catheterization labs in the service area will remain the same. The expansion of Erlanger East Hospital (CON No. CN0405-047AE) is in process. No other health care services will be initiated or discontinued.

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Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate Of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

38312337

STATE OF TENNESSEE
HAMILTON COUNTY

Before me personally appeared Pam Saynes who being duly sworn, that she is the Legal Sales Representative of the "CHATTANOOGA TIMES FREE PRESS" and that the Legal Ad of which the attached is a true copy, has been published in the above said Newspaper and on the website on the following dates, to-wit:

February 10, 2015

And that there is due or has been paid the "CHATTANOOGA TIMES FREE PRESS" for publication of such notice the sum of $672.40 Dollars. (Includes $10.00 Affidavit Charge).

Pam Saynes

Sworn to and subscribed before me, this 10th day of February 2015.

Amanda Crawford

My Commission Expires 10/17/2018

AMANDA CRAWFORD
STATE OF TENNESSEE
NOTARY PUBLIC
HAMILTON COUNTY
MY COMMISSION EXPIRES OCTOBER 17, 2018

Chattanooga Times Free Press

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38312337

State of Tennessee

Department of State

To all to whom these Presents shall come, Greeting:

I **Gentry Crowell**, Secretary of State of the State of Tennessee, do hereby certify that the annexed is a true copy of

PRIVATE CHAPTER NO. 125

SENATE BILL NO. 1499

PRIVATE ACTS OF 1977

the original of which is now on file and a matter of record in this office.

In Testimony Whereof, I have hereunto subscribed my Official Signature and by order of the Governor affixed the Great Seal of the State of Tennessee at the Department in the City of Nashville, this 13th day of June A.D. 19 77

Gentry Crowell

Secretary of State

PRIVATE CHAPTER NO 125

SENATE BILL NO. 1499

By Albright, Ortwein

Substituted for: House Bill No. 1514

By Robinson (Hamilton)

AN ACT To amend Chapter 297 of the 1976 Private Acts of Tennessee entitled "AN ACT To create a Governmental Hospital Authority to own and operate Baroness Erlanger Hospital, T. C. Thompson Children's Hospital and other related facilities and provide for the establishment and organization of a Board of Trustees for the operation thereof," relative to the Board of Trustees of said Hospital Authority and the powers and duties thereof, to the issuance of bonds and other obligations by the authority and the securing thereof, to the Financial Review Commitee with respect to the authority, and the duties and powers thereof, and to other provisions with respect to the duties and obligations of the authority, and validating and reenacting said Chapter No. 297 and ratifying all acts of the Board of Trustees of the authority.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Chapter 297 of the Private Acts of 1976 is amended by amending Section 1 thereof to read as follows:

"SECTION 1. A governmental Hospital Authority to be known as the Chattanooga-Hamilton County Hospital Authority, is hereby created and established for and on behalf of Hamilton County, Tennessee, for the purpose of performing a governmental function by operating Baroness Erlanger Hospital and T. C. Thompson Children's Hospital and such other similar or associated hospitals and existing health centers deemed appropriate to be operated by said authority as sole operator for the purpose of providing health care facilities and programs for the residents of Hamilton County, Tennessee."

SECTION 2. Chapter 297 of the Private Acts of 1976 is amended by deleting the first paragraph of Section 2 thereof and by substituting for such paragraph two new paragraphs to read as follows:

"SECTION 2. The Hospital Authority shall be operated upon the tracts and parcels of real property owned jointly by Hamilton County and the City of Chattanooga, Tennessee, and on which are situated the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital or upon any other real property acquired by the authority through gift and purchase. The city and the county are authorized and directed to convey and assign all real property constituting the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital to the authority. The city and the county are also authorized to convey and assign all personal property constituting the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital to the authority.

"In the event the authority shall at any time cease to exist as the operator of Baroness Erlanger Hospital, T. C. Thompson Children's Hospital and such other similar or associated hospitals and existing health centers deemed appropriate to be operated by the authority as sole operator, the real estate which was owned on August 5, 1976, by the county and the city and conveyed to the authority by the county and the city, shall revert in fee simple to the county, subject to such encumbrances as may be on said property at the time of reversion; provided, however, that the city shall have an option to require transfer to it of the title to the same proportion of such real estate as was owned by the city on such date, subject to such encumbrances on that portion of the real estate.

"If the authority shall at any time cease to use any such parcel or parcels of said real estate for hospital or related purposes for a period of two (2) years, then the county and the city shall have the option to require transfer to them of title to such parcel or parcels in fee simple, subject to such encumbrances as may be on said property at the time of such transfer of title, in the same proportion as such parcel or parcels were previously owned by the county and the city. In the event that either the county or the city shall elect not to exercise its option with respect to any such parcel or parcels of real estate, then the other of them shall have the option to require transfer to it of the entire parcel or parcels of real estate in question. In the event that neither the county nor the city decides that they wish to exercise said option, then the authority shall have the right to dispose of such property in whatever manner it deems appropriate."

SECTION 3. Chapter 297 of the Private Acts of 1976 is amended by amending Section 3 thereof to read as follows:

"SECTION 3. Said Hospital Authority shall be operated and controlled by a Board of Trustees consisting of eleven (11) members who shall serve without compensation but who shall be indemnified by the authority for any liability they might incur while acting in such capacity other than from culpable negligence. The original members of the Board of Trustees and their respective terms of office are declared to be those

individuals whose names are set out below, and upon expiration of such terms the members of the Board of Trustees shall be appointed by the county judge of the county, the mayor of the city, the chancellors of the chancery courts, and the legislative delegation for four (4) year terms as provided in the next succeeding paragraph hereof. The following are confirmed as the original members of the Board of Trustees and shall hold office for terms ending as follows (or until their successors are appointed):

Name of Trustee	Successor to be Appointed by	Term of Office Expires
David P. McCallie, M.D.	Mayor	11-1-80
Mrs. Vi Ketchersid	County Judge	11-1-80
Stan Guthrie	Chancellors	11-1-80
Harry W. McKaldin, Jr.	Mayor	11-1-78
Sibert Brewer, Jr.	County Judge	11-1-78
Don J. Russell, M.D.	Mayor and County Judge (with approval of medical society)	11-1-78
J. K. Lawrence	Mayor	11-1-78
John C. Cantrell	County Judge	11-1-78
Claude Ramsey	Legislative Delegation	11-1-78
Charles Griffin	Mayor	11-1-77
Forrest Cate	County Judge	11-1-77

"The method of appointment of the members of the Board of Trustees after the expiration of the terms of the original members of such board shall be as follows: The mayor of the city shall appoint four (4) trustees, with the approval of a majority of the members of the Board of Commissioners. The county judge of the county shall appoint four (4) trustees, with the approval of a majority of the members of the county council. Said mayor and county judge shall jointly appoint one (1) trustee with the approval of the president of the Chattanooga-Hamilton County Medical Society, Inc., acting with the approval of a majority of the House of Delegates of said society, and with the approval of a majority of the members, respectively, of the Board of Commissioners and of the county council. The chancellors of chancery court shall jointly appoint one (1) trustee. The legislative delegation shall by a majority vote appoint one (1) trustee.

"Upon the expiration of the term of office of any trustee, his successor shall be appointed for a term of four (4) years by the authority appointing the trustee whose term has expired. The original trustees, for all purposes of this section, shall be considered to have been appointed by the mayor, the county judge, the chancellors and/or the legislative delegation as indicated in the above tabulation.

"All such appointments to the Board of Trustees as provided herein shall be made without regard to religious preference, race, sex or national origin, and in the making of appointments due consideration shall be given to making said Board of Trustees representative, as nearly as may be practicable, of all residents of the city and county, including the various racial groups therein.

"Any member so appointed to the Board of Trustees may, for reasonable cause, be removed from his or her office in the same manner and by the same authority as such member was appointed to the office; provided that such removal shall be preceded by a full hearing and adequate notice of such hearing. 'Reasonable cause' shall include, but shall not be limited to, misconduct in office, failure to perform duties prescribed by this act or other applicable law, or failure to diligently pursue the objectives for which the authority was created.

"Vacancies on the Board of Trustees caused by any reason whatsoever, shall be filled by appointment of the authority who appointed the trustee vacating the office, but without the necessity of approval otherwise herein required. A trustee so appointed shall hold office for the remainder of the term of the trustee vacating the office.

"A member of the Board of Trustees may serve as such trustee for not more than eight (8) consecutive years, excluding any previous service as a member of the Board of Trustees of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital."

The occupancy of their respective offices by the present members of the Board of Trustees (being those individuals enumerated in amended Section 3 above) is hereby ratified and confirmed.

SECTION 4. Chapter 297 of the Private Acts of 1976 is amended by repealing Section 4 thereof and substituting therefor a new Section 4 to read as follows:

"SECTION 4. Whenever used in this act, unless a different meaning clearly appears from the context, the following terms whether used in the singular or the plural shall be given the following respective interpretations:

'Authority' or 'Hospital Authority' means the Chattanooga-Hamilton County Hospital Authority as created by this act.

'Board of Commissioners' means the Board of Commissioners of the city.

'Board of Trustees' means the Board of Trustees of the authority as provided for in this act.

'Bonds' means bonds of the authority authorized to be issued by this act. 'Advance refunding bonds' means bonds issued for the purpose of refunding outstanding bonds which will neither mature by their terms nor be subject to and called for redemption within a period of 30 days following the date of issuance of said advance refunding bonds.

'Chancellors' means the Chancellors of the Chancery Courts of Hamilton County, Tennessee.

'Chief Executive Officer' means, as the context requires, the president of the authority, the mayor of the city, and the county judge of the county.

'City' means the City of Chattanooga, Tennessee.

'County' or 'Hamilton County' means Hamilton County, Tennessee.

'County Council' means the county council of the county.

'County Judge' means the county judge or such other chief executive officer of the county as may be created by subsequent law.

'Financial Review Committee' means the Financial Review Committee provided for in this act.

'Hamilton County Sales Tax Agreement' means the agreement between the city and the county, dated March 23, 1966.

'Legislative Delegation' means the Hamilton County delegation to the Legislature of Tennessee, being the Senators and Representatives elected from those districts lying in whole or in part in the county.

'Mayor' means the mayor of the city or such other chief executive officer of the city as may be created by subsequent law.

'Notes' means notes of the authority authorized to be issued by this act. 'Short-Term Notes' means nonrenewable notes having a term no longer than three (3) years. 'Long-Term Notes' means renewable short-term notes and notes having a term longer than three (3) years.

'Project' or 'Facility' shall mean any one or combination of buildings, structures or facilities owned by the authority, including the site therefor and all machinery and equipment therein or necessary to the operation thereof, and shall include expressly the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital."

SECTION 5. Chapter 297 of the Private Acts of 1976 is amended by repealing Section 5 thereof and by renumbering Section 6 thereof as Section 5.

SECTION 6. Chapter 297 of the Private Acts of 1976 is amended by renumbering Section 7 thereof as Section 6 and by amending said renumbered Section 6 to read as follows:

"SECTION 6. The Board of Trustees shall be vested with the full, absolute and complete authority and responsibility for the complete operation, management, conduct and control of the business and affairs of the Hospital Authority herein created. This authority and responsibility shall include, but shall not be limited to, the establishment, promulgation and enforcement of the rules, regulations and policies of the authority, the granting of or the refusal of medical staff privileges, the upkeep and maintenance of all property, the administration of all financial affairs of the authority, including pledging of assets for expansion and improvement of facilities and any other necessary financial needs of the authority. The authority shall have, but shall not be limited to, the following powers together with all powers incidental thereto or necessary for the performance of those hereinafter stated: (1) to sue and be sued and to prosecute and defend, at law or in equity, in any court having jurisdiction of the subject matter and of the parties; (2) to have and use an official seal and to alter the same at pleasure; (3) to acquire, whether by purchase, construction, exchange, gift, lease, or otherwise, and to improve, maintain, extend, equip and furnish hospital and related facilities within the corporate limits of Hamilton County, including expressly, but without limitation, professional office buildings, ancillary residence facilities and data processing facilities, and including all real and personal properties which the Board of Trustees may deem necessary in connection therewith and regardless of whether or not any such facilities shall then be in existence; (4) to execute all contracts, agreements and other instruments with any person, partnership, corporation, federal, state, county or municipal government, including but not limited to the issuance of bonds, mortgages, notes and other forms of indebtedness, and contracts for the

management of hospital and clinic facilities (but no such management contract shall exceed two (2) years in length); (5) subject to the provisions of Section 2 hereof, to sell, lease, exchange, donate, and convey any or all of its properties whenever its Board of Trustees shall find any such action to be in furtherance of the purposes for which the authority was created; (6) to borrow money and issue its bonds and notes for the purpose of carrying out any of its powers; (7) as security for the payment of the principal of and interest on any bonds and notes so issued and any agreements made in connection therewith, to mortgage and pledge any or all of its facilities or any part or parts thereof, whether then owned or thereafter acquired, and to pledge all or any portion of the revenues and receipts therefrom or from any thereof; (8) to employ and pay compensation to such employees, and agents, including attorneys, accountants, engineers, architects and financial consultants, as the Board of Trustees shall deem necessary for the business of the authority; and (9) to establish bylaws and make all rules and regulations not inconsistent with the provisions of this act, deemed expedient for the management of the authority's affairs.

"No contract, except for personal services or lease obligations, involving an expenditure exceeding one thousand dollars ($1,000.00), nor several proposed contracts aggregating more than one thousand dollars ($1,000.00), for the same general work or kind of work, supplies or equipment, shall be awarded until after at least one advertisement in some newspaper of general circulation published in the county at least ten (10) days before such contract is awarded or supplies purchased, and then only to the lowest and best bidder. Said bids shall be sealed and filed with the president or his designee, who shall publicly open them on the date specified and not prior thereto. No entire project or purchase involving the same type of work, equipment or supplies shall be split into small contracts. Nothing in this paragraph shall be construed to apply to the issuance of bonds or notes by the authority.

"Purchases and contracts involving an expenditure of not more than one thousand dollars ($1,000.00) shall be made in conformity with the rules and regulations adopted by the Board of Trustees.

"The authority shall prescribe reasonable rates, fees and charges for the services and facilities furnished by the authority and shall revise such rates, fees and charges from time to time so as to produce revenue at least sufficient to pay the principal of and interest on all bonds and other obligations issued by the authority, including reserves therefor, and to pay the cost of maintaining and operating its facilities."

SECTION 7. Chapter 297 of the Private Acts of 1976 is amended by the addition of a new Section 7 thereto to read as follows:

"SECTION 7. Except as herein otherwise expressly provided, all bonds issued by the authority shall be payable solely out of and secured by a pledge of all or any portion of the revenues and receipts derived from the authority's projects or of any thereof as may be designated in the proceedings of the Board of Trustees under which such obligations shall be authorized to be issued and may be secured by a mortgage or deed of trust covering all or any part of the projects from which the revenues and receipts so pledged may be derived, as such projects may thereafter be extended or enlarged; provided, that notes issued in anticipation of the issuance of bonds may be retired out of the proceeds of such bonds. The proceedings under which the bonds are authorized and any such mortgage or deed of trust may contain agreements and provisions respecting the maintenance of the facilities covered thereby, the establishment of rates, fees and charges for the services and facilities furnished by the authority, the creation and maintenance of special funds from the revenues of the authority and the rights and remedies available in the event of default, all as the Board of Trustees shall determine advisable and not in conflict with the provisions of this act. Each pledge, mortgage and deed of trust made for the benefit or security of any bonds of the authority shall continue in effect until the principal of and interest on the bonds for the benefit of which the same were made shall have been fully paid. In the event of default in such payment or in any agreement of the authority made as a part of the contract under which the bonds were issued, whether contained in the proceedings authorizing the bonds or in any mortgage or deed of trust executed as security therefor, such payment or agreement may be enforced by suit, mandamus, the appointing of a receiver in equity or by foreclosure of any such mortgage or deed of trust, or any one or more of such remedies.

"Such bonds may be executed and delivered by the authority at any time and from time to time, may be in such form and denominations and of such terms and maturities, may be subject to redemption prior to maturity either with or without premium, may be in fully registered form or in bearer form registrable either as to principal or interest or both, may bear such conversion privileges and be payable in such installments and at such time or times not exceeding forty (40) years from the date thereof, may be payable at such place or places whether within or without the State of Tennessee, may bear interest at such rate or rates payable at such time or times and at such place or places and evidenced in such manner, may be executed by such officers of the authority, and may contain such provisions not inconsistent herewith, all as shall be provided in the proceedings of the Board of Trustees whereunder the bonds shall be authorized to be issued. Any bonds of the authority may be sold at public or private sale for such price and in such manner and from time to time as may be determined by the Board of Trustees to be most advantageous, and the authority may pay all expenses, premiums and commissions which its Board of Trustees may deem necessary or advantageous in connection with the issuance thereof.

"Proceeds of bonds and notes issued by the authority may be used for the purpose of constructing, acquiring, reconstructing, improving, equipping, furnishing, bettering, or extending any project or projects, including the payment of interest on the bonds during construction of any such project and for six (6) months after the estimated date of completion, the payment of engineering, fiscal, architectural, bond insurance and legal expenses incurred in connection with such project and the issuance of the bonds, and the establishment of a reasonable reserve fund for the payment of principal of and interest on such bonds in the event of a deficiency in the revenues and receipts available for such payment. Any bonds and long-term notes shall, except as herein otherwise expressly provided, be issued for capital expenditures and none of the proceeds shall be used for operational expenditures or routine maintenance needs.

"Except as hereinafter in this paragraph provided, the amount of bonds and notes of the authority which may be issued at any time, together with any bonds and notes of the authority then outstanding, shall not exceed an amount equal to ninety percent (90%) of the sum of the value of the existing plant, property and equipment of the authority at the time of issuance of such bonds plus the contract price of the improvements to be constructed, acquired and installed from the proceeds of such bonds, less (1) the principal amount outstanding, if any, of such bonds as may have been issued by the county for the expansion, remodeling, repairing, equipping, and/or construction of all or any part of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital, and (2) the amount, if any, of any unfunded portion of the employees' pension fund of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital. Plant, property and equipment for the purpose of the preceding sentence shall be stated at market value as determined by a professional appraiser to be selected by the Financial Review Committee. A certificate of such professional appraiser with respect to the value of such plant, property and equipment, a certificate of the county judge of the county with respect to the amount of outstanding bonds of the county for such hospital purposes, and a certificate of the chief executive officer of the authority with respect to the unfunded portion of such employees' pension fund shall each be conclusive for the purposes of determining the amount of bonds and notes which may be issued pursuant to this paragraph. The limitations expressed in this paragraph shall not apply to the issuance of advance refunding bonds.

"The Board of Trustees shall direct in the proceedings authorizing the issuance of any bonds of the authority that there shall be set aside and appropriated as a reserve for the payment of principal and interest on said bonds an amount not less than the required amount of principal and interest on the bonds falling due during the 12 month period next succeeding the date of issuance of the bonds."

"Any bonds or notes of the authority at any time outstanding may at any time and from time to time be refunded by the authority by the issuance of its refunding bonds in such amount as the Board of Trustees may deem necessary, but not exceeding the sum of the following: (a) the principal amount of the obligations being refinanced; (b) applicable redemption premiums thereon; (c) unpaid interest on such obligations to the date of delivery or exchange of the refunding bonds; (d) in the event the proceeds from the sale of the refunding bonds are to be deposited in trust

as hereinafter provided, interest to accrue on such obligations from the date of delivery to the first or any subsequent available redemption date or dates selected, in its discretion, by the Board of Trustees, or to the date or dates of maturity, whichever shall be determined by the Board of Trustees to be most advantageous or necessary to the authority; and (e) expenses, premiums and commissions of the authority, including bond discount, deemed by the Board of Trustees to be necessary for the issuance of the refunding bonds. A determination by the Board of Trustees that any refinancing is advantageous or necessary to the authority, or that any of the amounts provided in the preceding sentence should be included in such refinancing, or that any of the obligations to be refinanced should be called for redemption on the first or any subsequent available redemption date or permitted to remain outstanding until their respective dates of maturity, shall be conclusive.

"Any such refunding may be effected either by the exchange of the refunding bonds for the obligations to be refunded thereby with the consent of the holders of the obligations so to be refunded, or by sale of the refunding bonds and the application of the proceeds thereof to the payment of the obligations to be refunded thereby, in the manner herein provided.

"Prior to the issuance of the refunding bonds, the Board of Trustees shall cause notice of its intention to issue the refunding bonds, identifying the obligations proposed to be refunded and setting forth the estimated date of delivery of the refunding bonds, to be given to the holders of the outstanding obligations by publication of an appropriate notice one (1) time each in a newspaper having general circulation in Hamilton County and in a financial newspaper published in New York, New York, and having national circulation. As soon as practicable after the delivery of the refunding bonds, and whether or not any of the obligations to be refunded are to be called for redemption, the Board of Trustees shall cause notice of the issuance of the refunding bonds to be given in the manner provided in the preceding sentence.

"If any of the obligations to be refunded are to be called for redemption, the Board of Trustees shall cause notice of redemption to be given in the manner required by the proceedings authorizing such outstanding obligations.

"The principal proceeds from the sale of any refunding bonds shall be applied only as follows: either,

(a) to the immediate payment and retirement of the obligations being refunded; or

(b) to the extent not required for the immediate payment of the obligations being refunded then such proceeds shall be deposited in trust to provide for the payment and retirement of the obligations being refunded and to pay any expenses incurred in connection with such refunding, but provision may be made for the pledging and disposition of any surplus, including, without limitation, provision for the pledging of any such surplus to the payment of the principal of and interest on any issue or series of refunding bonds. Money in any such trust fund may be invested in direct obligations of, or obligations the timely payment of principal of and interest on which are fully guaranteed by the United States government, or obligations of any agency or instrumentality of the United States government, or in certificates of deposit issued by a bank or trust company located in the State of Tennessee if such certificates shall be secured by a pledge of any of said obligations having an aggregate market value, exclusive of accrued interest, equal at least to the principal amount of the certificates so secured. Nothing herein shall be construed as a limitation on the duration of any deposit in trust for the retirement of obligations being refunded but which shall not have matured and which shall not be presently redeemable or, if presently redeemable, shall not have been called for redemption."

SECTION 8. Chapter 297 of the Private Acts of 1976 is amended by adding at the end of the third paragraph of Section 9 thereof a new sentence to read as follows:

"A certificate by such actuary with respect to the currency of such required pension fund contributions shall be conclusive for the purpose of determining compliance by the authority with the provisions of this section."

SECTION 9. Chapter 297 of the Private Acts of 1976 is amended by adding a new sentence to the end of Section 10 thereof, said new sentence to read as follows:

"Notwithstanding the foregoing provisions of this section, nothing herein contained shall be construed as limiting any expenditures made by the authority for the payment of principal of and in-

terest on bonds or other obligations issued by the authority."

SECTION 10. Chapter 297 of the Private Acts of 1976 is amended by amending Section 11 thereof to read as follows:

"SECTION 11. A Financial Review Committee shall be created consisting of seven (7) members, one (1) of whom shall be Black. The membership shall be composed of the auditor of the city, the auditor of the county, and five (5) other persons who are residents of Hamilton County, three (3) of whom shall be appointed by the county judge with the approval of a majority vote of the county council and two (2) of whom shall be appointed by the mayor with the approval of a majority vote of the Board of Commissioners; provided, that if any members of such committee shall not have been so appointed within 90 days from the date of approval of this act by the county council of the county, such members shall thereupon be appointed by a majority vote of the members of the legislative delegation.

"The members of the committee shall serve without compensation. They shall be indemnified by the authority for any liability they might incur while acting in such capacity other than for culpable negligence. With the exception of the city auditor and the county auditor, the remaining members shall be initially appointed to staggered terms as follows: two (2) for terms of three (3) years; one (1) to be so appointed by the county judge and one (1) to be so appointed by the mayor; two (2) for terms of two (2) years; one (1) to be so appointed by the county judge and one (1) to be so appointed by the mayor; and one (1) to be so appointed by the county judge for a term of one (1) year. Thereafter, each appointee shall serve for a period of three (3) years and such appointee's successor shall be appointed in the same manner and by the same official who appointed the person whose term has expired. Any person appointed to fill a vacancy for any reason other than expiration of term of office shall be appointed to hold office for the remainder of the term of the member vacating the office. Said vacancy shall be filled in the same manner as the original appointment.

"The Financial Review Committee shall review the proposed issuance of bonds or long-term notes, to consider if the issuance of said obligations is within the fiscal ability of the authority based upon the appropriate preceding annual audits, monthly operating statements subsequent to the closing date of the most recent audit period included in the most recent annual audit, additional revenue projections reasonably anticipated as a result of the proposed capital expenditure (taking into account any probable revenue loss during replacement, if any), and any other data reasonably bearing upon the fiscal soundness of the issuance of such bonds or long-term notes. At such time or times as the Board of Trustees of the authority shall desire to authorize the issuance of bonds or long-term notes it shall first submit the proposal to issue such obligations to the Financial Review Committee, which committee shall file its advisory report thereon with the Board of Trustees within sixty (60) days after the receipt of such proposal. Upon the filing of such report with the Board of Trustees, or after sixty (60) days following the date of submission of such proposal to such committee, whichever is earlier, the Board of Trustees may proceed with the issuance of such bonds or long-term notes; provided, that the submission to the Financial Review Committee herein required shall not be necessary at any time if such committee has not then been validly appointed and is not in existence.

"The Financial Review Committee shall annually review the proposed budget prepared by the Board of Trustees and shall file its report thereon with the Board of Trustees and the County Council.

"All reports of the Financial Review Committee shall be made to the County Council of the county, the Board of Commissioners of the city and the Board of Trustees of the authority, and shall be considered by the respective governing bodies with which such reports are filed."

SECTION 11. Chapter 297 of the Private Acts of 1976 is amended by adding six new sections thereto to be numbered 17 to 22, inclusive, and to read as follows:

SECTION 17. Notwithstanding any other provision of this act the county shall have the option to purchase all real and personal property of the authority if either of the following shall have occurred:

(a) The authority shall have defaulted in the payment when due of principal or interest on any of its bonds or long-term notes then outstanding; or

(b) The authority shall have filed written notice with the county judge that it is the expectation of the Board of Trustees of the authority that the authority will so default in the payment of principal of or interest on any of its bonds or long-term notes then outstanding on the next succeeding date on which such principal or interest shall fall due.

"The purchase price in the event that the county shall elect to exercise any such option shall be an amount equal to the principal of and interest to maturity or the first call date, if any, whichever shall be earlier, together with any applicable premiums, on all bonds and long-term notes of the authority then outstanding, and the amount so received by the authority from the county shall be impressed with a trust in favor of the holders of such bonds and long-term notes and shall be used for the payment of principal of and interest and redemption premiums thereon and for no other purpose.

"Such purchase option of the county shall be superior to any right of foreclosure herein permitted, and any mortgage hereinafter granted by the authority shall recognize and be subject to such option to purchase.

"SECTION 18. The authority is hereby declared to be a public instrumentality acting on behalf of the county, but without the power of eminent domain, and in that connection to be fulfilling a public function, and the authority and all properties at any time owned by it and the income therefrom and all bonds or notes issued by the authority and the income therefrom shall be exempt from all taxation in the State of Tennessee. Also, for purposes of the Securities Law of 1955, compiled as Sections 48-1601 through 48-1648, Tennessee Code Annotated, and any amendment thereto or substitution therefor, bonds or notes issued by the authority shall be deemed to be securites issued by a public subdivision of the State of Tennessee.

"SECTION 19. The authority shall be a public nonprofit corporation and no part of its net earnings remaining after payment of its expenses shall inure to the benefit of any individual, firm or corporation.

"SECTION 20. Neither the county nor the city shall in any event be liable for the payment of the principal of or interest on any bonds or notes of the authority or for the performance of any pledge, mortgage, obligation or agreement of any kind whatsoever which may be undertaken by the authority, and none of the bonds or notes of the authority or any of its agreements or obligations shall be construed to constitute an indebtedness of either the county or the city within the meaning of any constitutional or statutory provision whatsoever.

"SECTION 21. Nothing contained in this act shall be construed to impair any contract rights which may have vested prior to the enactment of this act.

"SECTION 22. It is hereby declared that the purpose of this act is to facilitate adequate hospital facilities for the residents of the county. Bonds may be issued under this act without regard to the requirements, restrictions or procedural provisions contained in any other law."

SECTION 12. Chapter 297 of the Private Acts of 1976 is hereby in all respects ratified and confirmed and said act as herein amended is hereby reenacted by this General Assembly.

SECTION 13. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect any other provisions or application of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 14. This act shall have no effect unless it is approved by a two-thirds vote of the County Council of Hamilton County. Its approval or nonapproval shall be proclaimed by the presiding officer of the county council and certified by such officer to the Secretary of State.

SECTION 15. For the purpose of approving this act as provided in Section 14 it shall take effect on becoming law, the public welfare requiring it, but for all other purposes it shall be effective only upon being approved as provided in Section 14.

SENATE BILL NO. 1499

PASSED: May 19, 1977

SPEAKER OF THE SENATE

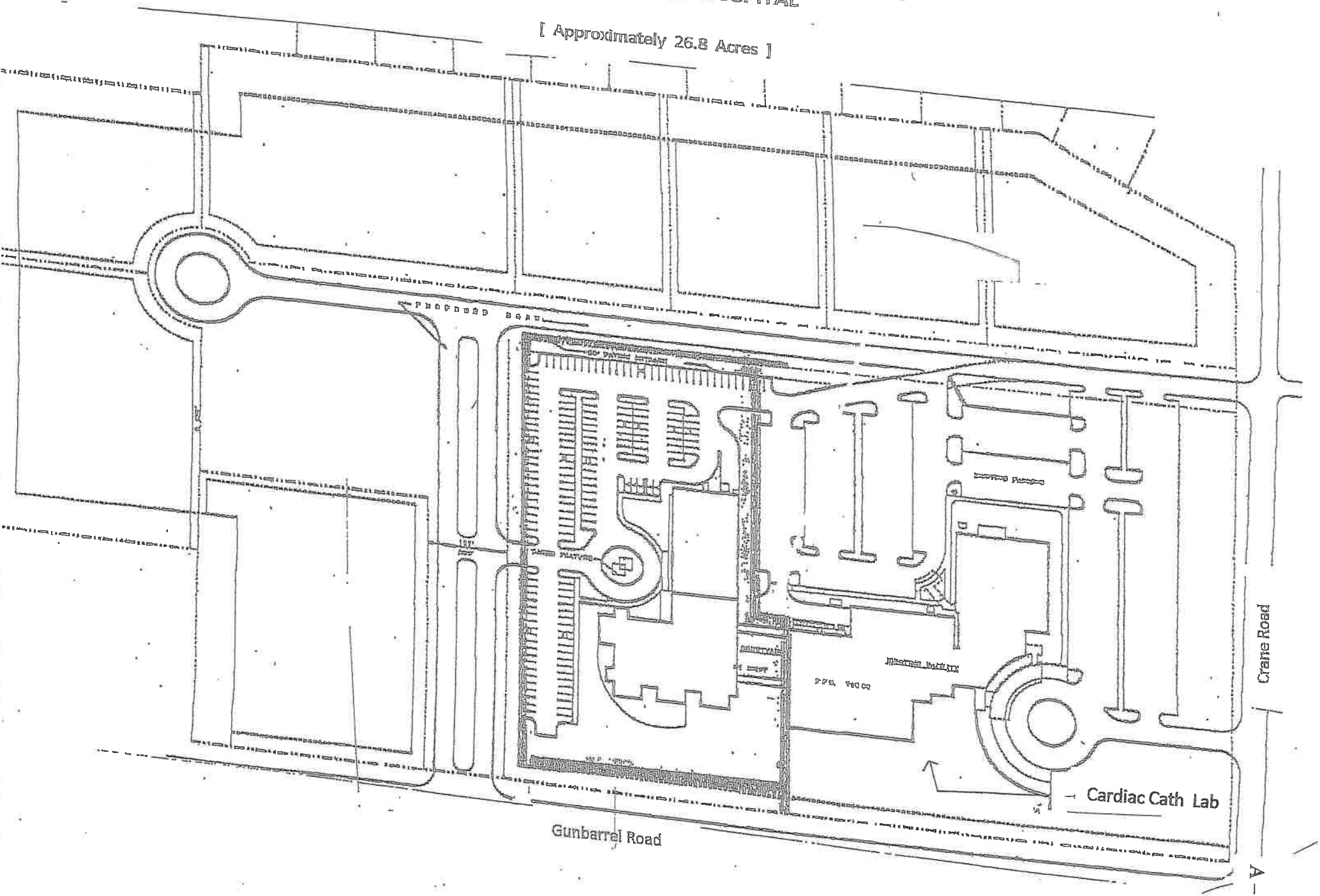
SPEAKER OF THE HOUSE OF REPRESENTATIVES

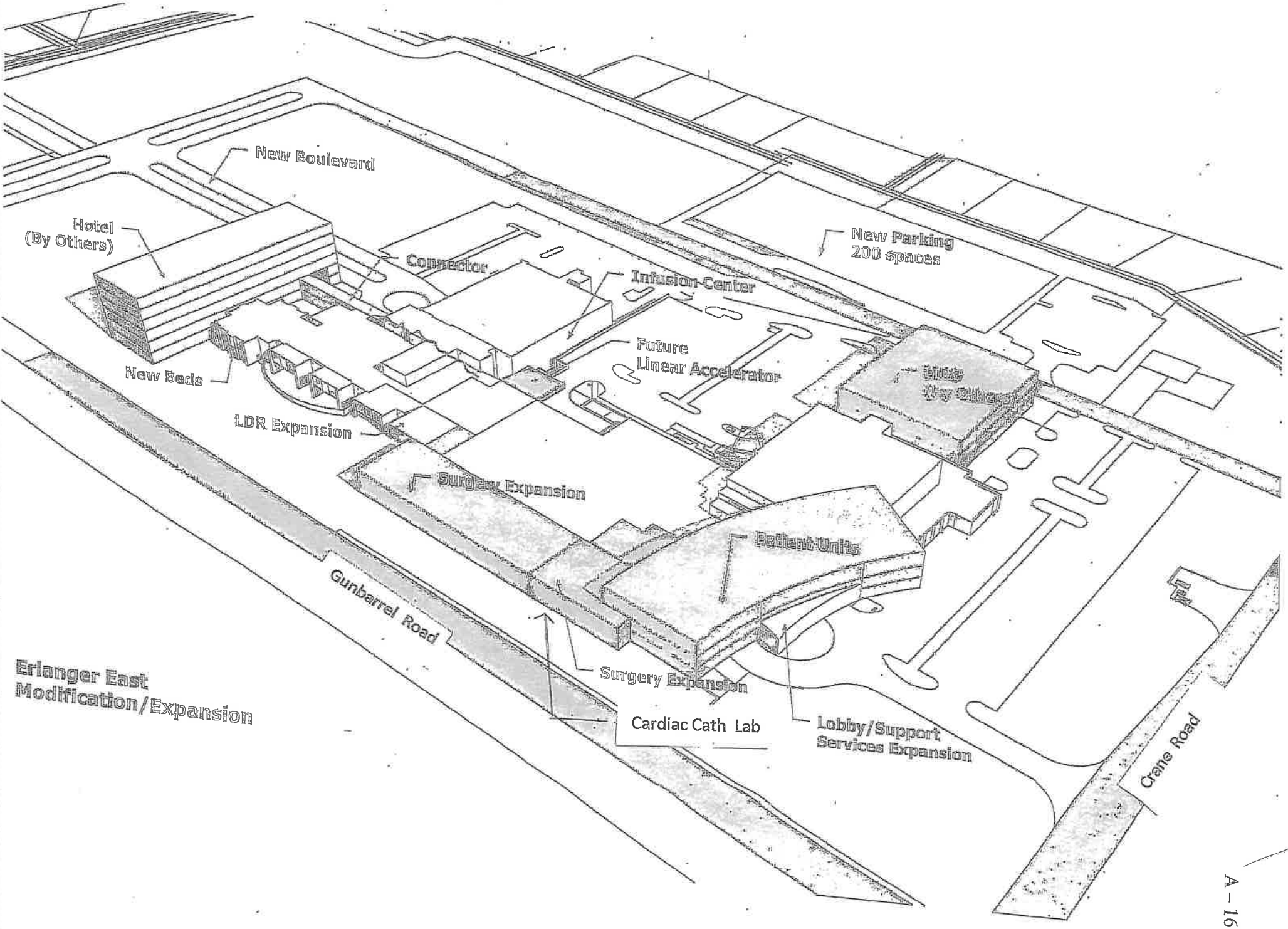
APPROVED this 28th day of May 19 77

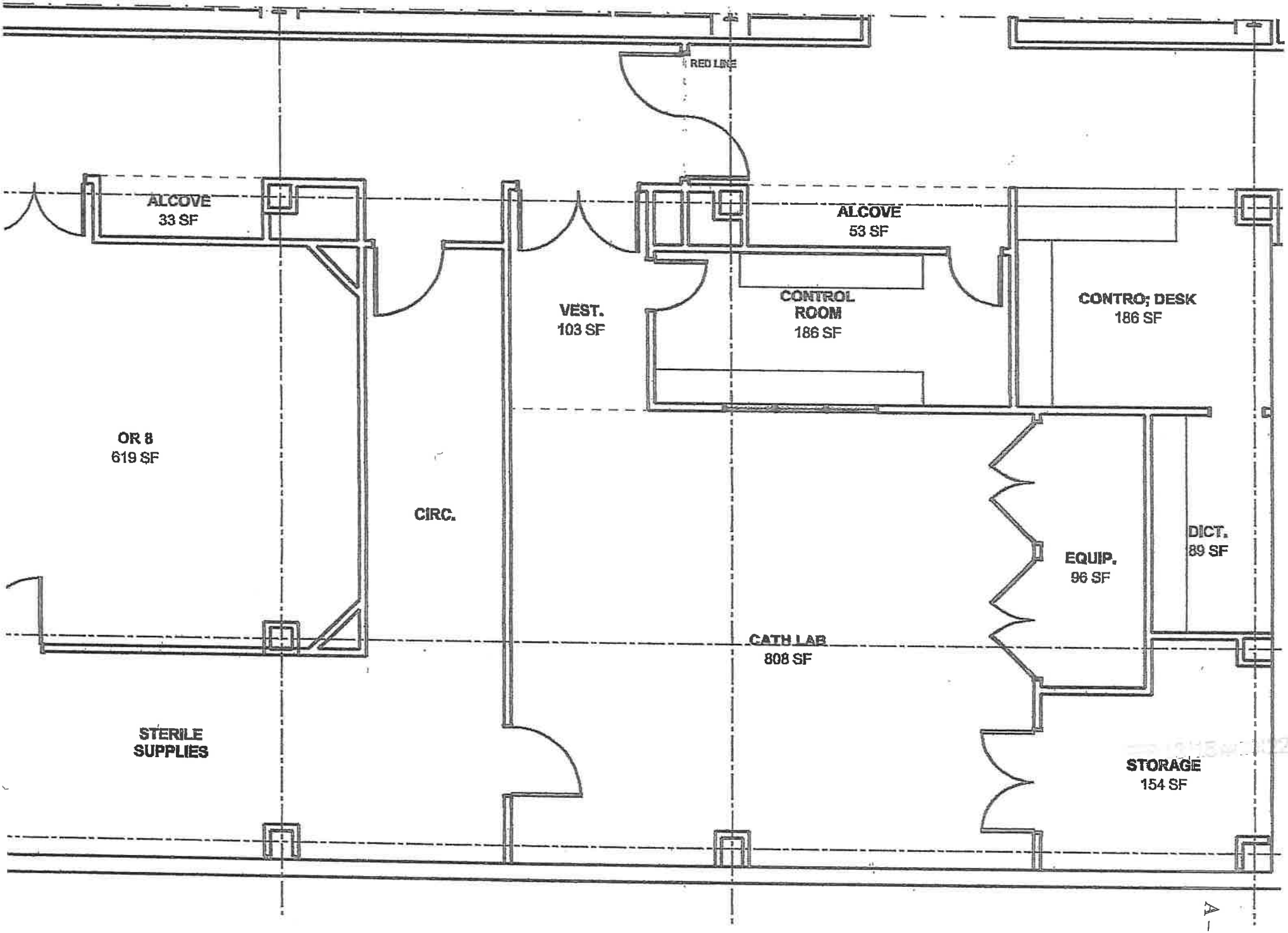
GOVERNOR

ERLANGER EAST HOSPITAL

[Approximately 26.8 Acres]




New Boulevard
Hotel
(By Others)
Connector
Infusion Center
New Parking
200 spaces
Future
Linear Accelerator
New Beds
LDR Expansion
Surgery Expansion
Patient Units
Gunbarrel Road
Erlanger East
Modification/Expansion
Surgery Expansion
Cardiac Cath Lab
Lobby/Support
Services Expansion
Crane Road


RED LINE
ALCOVE
33 SF
ALCOVE
53 SF
VEST.
103 SF
CONTROL
ROOM
186 SF
CONTRO; DESK
186 SF
OR 8
619 SF
CIRC.
EQUIP.
96 SF
DICT.
89 SF
CATH LAB
808 SF
STERILE
SUPPLIES
STORAGE
154 SF

LAWYERS TITLE AND ESCROW, INC.
DOME BUILDING
736 Georgia Avenue
Chattanooga, Tn. 37402
(615) 756-4154

WARRANTY DEED

Prepared by:
ROBERT L. BROWN, Attorne
100 Dome Building
736 Georgia Avenue
Chattanooga, Tn. 37402

BOOK 3553 PAGE 712

FILE NO. 880536
crs

DATE: November 15, 1988

THIS INDENTURE between

JAMES C. HUDSON, JR. AND WIFE, SHARON D. HUDSON,

as party or parties of the first part, hereinafter called Grantor, and

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY, A GOVERNMENTAL HOSPITAL AUTHORITY,

as party or parties of the second part, hereinafter called Grantee (the words "Grantor" and "Grantee" to include the parties named herein and their respective heirs, successors and assigns);

WITNESSETH that Grantor, for and in consideration of the sum of One Dollar and other good and valuable considerations, the receipt whereof is hereby acknowledged, does hereby convey to Grantee in fee simple, the following described property:

All that tract or parcel of land lying and being in the City of Chattanooga, Hamilton County, Tennessee, being a part of the Northwest Quarter of Section 14, Township 2, South, Range 3, West of the Basis Line, Ocoee District and being more particularly described as: Beginning at the intersection of the southern right-of-way of Crane Road (allowing for a width of 50 feet) with the western line of Gunbarrel Road; thence South 23 degrees 00 minutes 35 seconds West along said western right-of-way 1313.76 feet to a point; thence North 66 degrees 22 minutes West 934.73 feet to the southeast corner of Lot 14, Eastover Acres Subdivision, as shown by plat recorded in Plat Book 24, Page 40, in the Register's Office of Hamilton County, Tennessee; thence along the eastern line of Eastover Acres Subdivision, North 22 degrees 56 minutes East 1071.8 feet to a point; thence along the southeastern line of Eastover Acres Subdivision, North 48 degrees 55 minutes East 267.6 feet to a point on the southern right-of-way of Crane Road; thence along said southern right-of-way of Crane Road, South 66 degrees 22 minutes East 819.24 feet to the point of Beginning. Said tract containing 27.89 acres as shown on survey by Alfred L. allen dated October, 1987.

Being the same property conveyed by deeds recorded in Bok 2090, Page 227 and Book 3444, Page 417, said Register's Office.

This conveyance is made subject only to the following:

Sewer easement to City of Chattanooga, recorded in Book 2448, Page 305, said Register's Office.

Utility easement, the center line of which runs along the eastern and southeastern lines of Eastover Acres, as shown by plat recorded in Plat Book 24, Page 40, said Register's Office.

Anchor easement in the southwest corner of the property as shown on said plat.

Address of Grantee	Mail Tax Notice to	Map Parcel No.
Sr. Vice President - Finance Chattanooga-Hamilton County Hospital Authority	SAME	158D-G-27

TO HAVE AND TO HOLD said property and all rights appurtenant thereto, to Grantee forever in FEE SIMPLE.

Grantor warrants that Grantor is lawfully seized and possessed of said property, has full power and lawful authority to convey same, that Grantor's title is marketable, clear, free and unencumbered except as set forth herein, and that Grantor will forever defend the right and title to said property unto Grantee against the claims of all persons whomsoever.

IN WITNESS WHEREOF, Grantor has signed and sealed this Deed the day and year above written.

James C. Hudson, Jr.

Sharon D. Hudson

NO TRANSFER TAX DUE
SARAH P. DeFRIESE
County Register

F 3 4 4 5

IDENTIFICATION REFERENCE.

Nov 15 2 03 PM '88

SARAH P. DEFRIESE
REGISTER
HAMILTON COUNTY
STATE OF TENNESSEE

11/15/88 CONV 1,255,050.00 ✓
11/15/88 W/DD 8.00 **8.00 B

STATE OF TENNESSEE COUNTY OF HAMILTON

Before me, the undersigned Notary Public of the state and county aforesaid, personally appeared James C. Hudson, Jr. and wife, Sharon D. Hudson

the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence, and who acknowledged that they executed the within instrument for the purposes therein contained.

WITNESS my hand, at office, this 15th day of November 19 88.

Date of Expiration of Commission: 8-12-89

Robert L Brown
Notary Public (SEAL)

STATE OF _____ COUNTY OF _____

Before me, the undersigned Notary Public of the state and county aforesaid, personally appeared _____, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence, and who, upon oath, acknowledged himself to be the _____ of the _____, the within named bargainor, a corporation, and that he, as such officer, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by himself as such officer.

WITNESS my hand, at office, this _____ day of _____, 19____.

Date of Expiration of Commission: _____

Notary Public (SEAL)

STATE OF TENNESSEE COUNTY OF HAMILTON

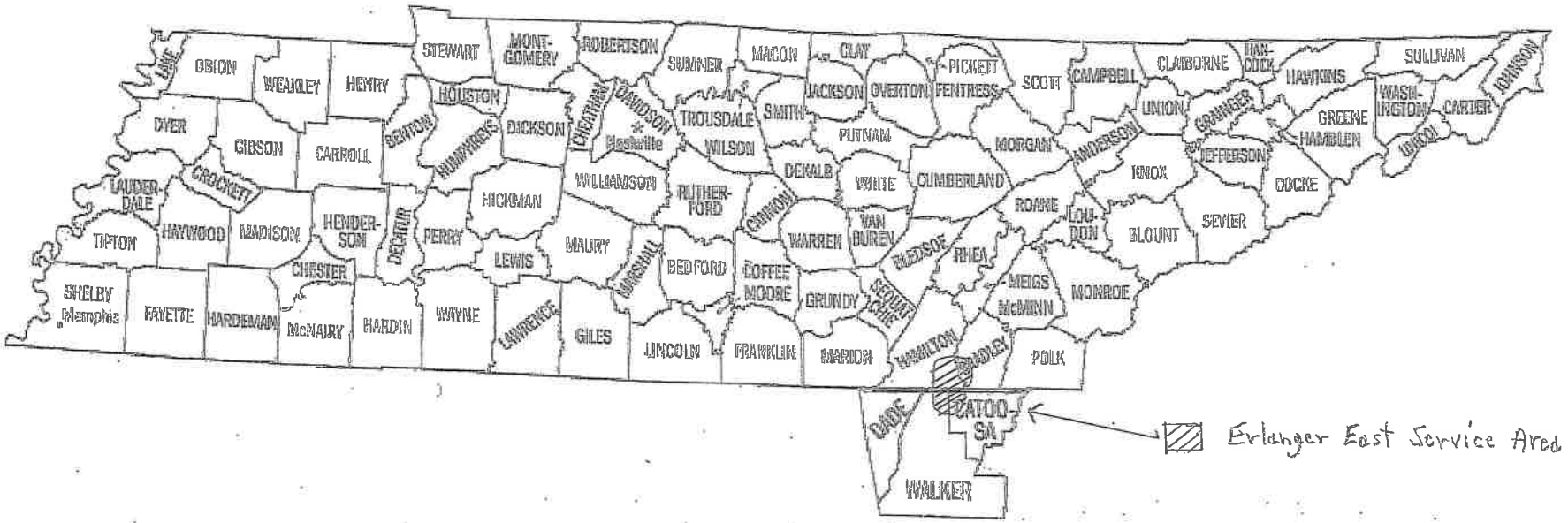
The undersigned Grantee hereby swears or affirms that the actual consideration for this transfer, or value of the property transferred, whichever is greater, is $ 1,255,050.00 which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale

L H Kennedy Comm. Exp.

Signed and sworn to or affirmed before me on this the 15th day of Nov 19 88

Date of Expiration of Commission 8-12-89

Robert L Brown
Notary Public (SEAL)


LAKE
OBION
WEAKLEY
HENRY
STEWART
MONT-GOMERY
ROBERTSON
SUMNER
MACON
CLAY
PICKETT
SCOTT
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CLAIBORNE
HAN-COCK
HAWKINS
SULLIVAN
DYER
GIBSON
CARROLL
BENTON
HUMPHREYS
DICKSON
CHEATHAM
DAVIDSON & Nashville
TROUSDALE
WILSON
SMITH
JACKSON
OVERTON
FENTRESS
PUTNAM
MORGAN
UNION
GRAINGER
GREENE
HAMBLEN
WASH-INGTON
CARTER
JOHNSON
UNICOI
LAUDER-DALE
CROCKETT
HAYWOOD
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DECATUR
PERRY
HICKMAN
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ANDERSON
KNOX
JEFFERSON
COCKE
TIPTON
CHESTER
LEWIS
MAURY
MARSHALL
BEDFORD
CANNON
WARREN
VAN BUREN
ROANE
LOU-DON
BLOUNT
SEVIER
SHELBY Memphis
FAYETTE
HARDEMAN
McNAIRY
HARDIN
WAYNE
LAWRENCE
GILES
COFFEE
MOORE
GRUNDY
SEQUATCHIE
BLEDSOE
RHEA
MEIGS
McMINN
MONROE
LINCOLN
FRANKLIN
MARION
HAMILTON
BRADLEY
POLK
DADE
CATOO-SA
WALKER
Erlanger East Service Area

erlanger

February 10, 2015

Ms. Melanie M. Hill, Executive Director
Tennessee Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deadrick Street
Nashville, TN 37243

RE: Cardiac Catheterization Laboratory
Erlanger East Hospital

Dear Ms. Hill,

This letter serves to confirm Erlanger's intent to defray the cost of the modernization of the Cardiac Catheterization Laboratory $ 303,000 with funds from operations; subject to CON approval as well as approval of the Chattanooga-Hamilton County Hospital Authority.

Please let me know if you have any questions or need further information. Thank you for your consideration.

Sincerely,

J. Britton Tabor, CPA
Executive V. P. & CFO/Treasurer

EHS – Analysis Of Average Inpatient Charges
For CY 2013

	Erlanger Med Ctr	Memorial Hosp	Parkridge Med Ctr	Erlanger East	Memorial Hosp-Hixson	Parkridge East Hosp
Adverse Effects	23,632	24,363	25,768		20,302	26,192
Back & Spine	56,372	62,321	77,068		19,805	63,991
Burns	41,854		79,165			16,129
Cardiac Surgery	121,317	124,382	187,761			
Dermatology	12,638	18,047	22,945		15,063	22,421
Electrophysiology / Devices	68,224	64,498	137,067		33,055	106,849
Endocrinology	16,973	20,382	34,172		15,515	30,963
Gastroenterology	20,922	23,279	37,279	7,649	19,865	31,826
General Cardiology	20,092	23,017	33,878		20,564	32,532
General Surgery	56,962	44,511	72,165	44,632	33,317	44,307
Gynecology	30,925	34,881	41,628	22,990	19,142	27,419
Hematology	18,019	25,288	55,193		24,342	38,090
HIV Infection	43,118	36,835	38,690		17,866	42,950
Infectious Diseases	48,905	48,026	78,291		29,658	67,501
Invasive Cardiology	46,338	43,668	89,668		33,878	84,705
Neonatology	57,502			10,439		45,521
Nephrology	19,648	24,320	35,305	11,355	19,051	31,393
Neurology	27,560	25,879	36,859		22,363	33,884
Neurosurgery	69,488	35,049	49,150		29,527	39,255
Obstetrics	11,227	12,221	8,801	7,956	5,393	13,730
Oncology	27,498	35,313	59,406		23,053	53,594
Ophthalmology	19,265	17,105	40,009		12,855	30,541
Oral Surgery	15,522	16,295	20,298		14,870	23,542
Orthopedics	45,886	40,948	51,258	39,291	37,175	49,102
Other	69,279	49,940	104,685	19,106	52,845	57,632
Otolaryngology	27,603	22,553	22,753		13,316	34,816
Plastic Surgery	48,458	33,725	49,094		23,011	79,799
Psychiatry	16,521	16,554	41,849		19,930	29,693
Pulmonary Medicine	70,570	40,588	54,690		27,048	45,468
Rehabilitation			59,765			
Rheumatology	26,929	28,367	35,702		11,344	85,627
Signs & Symptoms	15,456	19,239	30,847		14,499	34,786
Substance Abuse	17,311	20,504	35,410		17,257	32,229
Thoracic Surgery	43,438	55,261	81,953		18,872	61,596
Transplant Surgery	133,754	297,366	#DIV/0!			
Urology	35,591	37,434	46,512	25,739	20,161	29,775
Vascular Diseases	16,605	20,754	28,747		13,739	26,520
Vascular Surgery	67,895	75,014	100,399		48,503	108,824
Total	37,396	40,269	61,289	9,085	25,131	29,292

Source: EHS Planning

Charge Code	Description	CPT Code	UB Revenue Code	Charge Amount
50100205	ENDOCARDIAL BIOPSY	93505	481	2006.00
50100288	INSERTION IABP		360	658.00
50100478	TEMPORARY PACER INSERT		360	1408.00
50100486	THROMBOLYSIS INTRACOR INF	92975	480	518.00
50100494	TRANSCATHETER BIOPSY		360	1203.00
50100502	VALVULOPLASTY,PULMONARY	92990	481	7911.00
50100551	INSRT,FLOW DIR.CATH,MNTRNG	93503	481	700.00
50100650	AORTIC VALVULOPLASTY	92986	480	7911.00
50100668	VALVULOPLASTY,MITRAL,BALLOON	92987	480	7911.00
50100692	IVUS CORONARY INITIAL	92978	480	1628.00
50100700	IVUS CORONARY ADDITIONAL	92979	480	1628.00
50100718	RT HEART CATH,CONGEN ANOM	93530	481	12820.00
50100809	RHC & LHC,CONGEN ANOM	93531	481	11298.00
50100817	RHC & TRANSSEPT LHC W/INT SEPT	93532	481	12820.00
50100825	SI ANGIO PELVIC SELECT/SUPRA	75736	323	1523.00
50100866	RHC & TRANS LHC THRU EXIST SEP	93533	481	11044.00
50100908	SI PTA VENOUS	75978	320	1720.00
50100916	SI ANGIO VISCERAL SELECT/SUPR	75726	323	3342.00
50100957	SI ANGIO IVC	75825	320	1999.00
50100965	SI ANGIO SVC	75827	320	1832.00
50100973	SI VENOGRAM EXTREMITY BILAT	75822	320	742.00
50100981	SI VENOGRAM EXTREMITY UNILAT	75820	320	598.00
50100999	SI VENOGRAM RENAL BILATERAL	75833	320	997.00
50101005	SI VENOGRAM RENAL UNILATERAL	75831	320	979.00
50101096	PTA VENOUS		360	1544.00
50101112	SEL CATH PLACE VEN 1ST ORDER		360	1320.00
50101120	SEL CATH PLACE,VEN 2ND ORDER		360	1320.00
50101138	INJ CONTRAST VENOGRAPHY		360	563.00
50101146	INTRO CATH,VENA CAVA,SUPER/INF		360	488.00
50101153	TRANSCATH OCCL/EMBOL PERC		360	6650.00
50101187	TRANSCATH INF NON-THROMB		361	2319.00
50101245	SI TRANSCATHETER BIOPSY	75970	320	1237.00
50101385	F.B. RETRIEVAL/EXTRACTION		360	2656.00
50101401	PERICARDIOCNT INIT		360	602.00
50101419	PERICARDIOCNT SUB		360	602.00
50101427	US INTRAVASC INITL VSSL NONCOR	75945	320	291.00
50101435	US INTRAVASC ADDTL VSSL NONCOF	75946	320	276.00
50101542	ROTOBLADER ADVANCER	C1894	272	320.00
50101559	ROTOBLADER BURRS	C1724	272	1432.00
50101591	ANGIO KIT 3-HOLE		272	103.00
50101617	PERICARDIOCENTESIS TRAY	C1729	272	222.00
50101633	MERIT INTELLIFLATOR KIT		270	146.00
50101641	CATH, GUIDING, PCI-ALL C1887	C1887	272	128.00
50101716	STENT JJ UNMOUNTED	C1877	278	2484.00
50101765	SHEATH ARROW LONG	C1894	272	288.00
50101773	SHEATH ARROW SHORT	C1894	272	133.00
50101856	ARROW PROTECT SHIELD		270	40.00
50101864	IVUS PERIPHERAL INITIAL		360	4068.00
50101872	IVUS PERIPHERAL ADDITIONAL		360	4068.00
50102219	GUIDEWIRE,ROTOBLADER	C1769	272	230.00
50102417	GUIDEWIRE, GLIDE/HYDROPHILLIC	C1769	272	136.00
50102458	CATH, PIGTAIL, DUAL LUMEN		272	145.00
50102508	STENT GUIDE,LEMATRE		272	117.00
50102516	SHEATH, CRDS, BRITE TIP	C1894	272	121.00
50102540	GUIDEWIRE GOLD GLIDEWIRE	C1769	272	400.00

Charge Code	Description	CPT Code	UB Revenue Code	Charge Amount
50102557	GUIDEWIRE GOLD 180CM	C1769	272	228.00
50102623	BALLOON PERIPHERAL 3	C1725	272	544.00
50102730	CATH,DIAGNOSTIC/PERIPH		272	70.00
50102797	DILATOR, NO-WIRE, ALL		272	32.00
50102946	CATHETER IVUS CORONARY	C1753	272	1024.00
50103050	CATH THROMBECTOMY ANGIOJET	C1757	272	2385.00
50103068	CLOSDEV ANGIOSL STRCLSE MYNX	C1760	278	514.00
50103076	CLOSURE,ART DEVICE,PERCLOSE	C1760	278	352.00
50103084	GUIDEWIRE, ALL PCI	C1769	272	163.00
50103357	STENT PERIPHERAL BM 4	C1876	278	3500.00
50103373	STENT,PCI BM-1	C1876	278	1600.00
50103530	BALLOON PERIPHERAL SIZING 1	C2628	272	500.00
50103605	SHEATH DELIVERY/EXCHANGE	C1894	272	1044.00
50103662	AMPLATZER SEPTAL OCCLUDER	C1817	278	12150.00
50103787	ASD/PFO CLOSURE	93580	481	17770.00
50104009	BALLOON PERIPHERAL 1	C1725	272	288.00
50104017	BALLOON CUTTING BSCI	C1725	272	1240.00
50104041	COIL, EMOBOLIZATION		278	212.00
50104058	BALLOON, IABP		272	1360.00
50104066	STENT PERIPHERAL BM 2	C1876	278	2500.00
50104108	STENT PERIPHERAL BM 1	C1876	278	2300.00
50104173	STENT PERIPHERAL BM 3	C1876	278	3190.00
50104181	STENT PERIPHERAL BM 5	C1876	278	3990.00
50104215	FLUOROSCOPY/ROC	76000	320	281.00
50104231	TEMP TRANSCUTANEOUS PACING	92953	481	222.00
50108026	I&D SOFT TISS NECK 21501		360	652.00
50110014	PTA RENAL TX		360	1544.00
50110022	PTA AORTIC TX		360	1544.00
50110055	PTA BRACHIO/SCA TX		360	1544.00
50110089	NDL/CATH R BRCH ART		360	179.00
50110097	NDL/INCATH EXT ART		360	179.00
50110105	CATH AORTA		360	179.00
50110113	CATH 1ST ORD UP ART		360	179.00
50110121	CATH 2ND ORD UP ART		360	179.00
50110139	CATH 3RD ORD UP ART		360	179.00
50110147	CATH EA ADD'L UP ART		360	179.00
50110154	CATH 1ST OD LOW ART		360	179.00
50110162	CATH 2ND OD LOW ART		360	179.00
50110188	CATH EA ADD'L LOW ART		360	179.00
50110196	THROMBOLYSIS ANY TX		360	670.00
50110204	ARTERIAL EMBOLIZATION TX		360	3929.00
50110212	STENT INTRAVASCULAR TX		360	9672.00
50110220	STENT ADD'L VESSEL TX		360	3770.00
50110238	EXCHANGE CATH TX		360	2656.00
50110246	SI AORTOGRAM THORACIC	75605	323	1388.00
50110253	SI AORTOGRAM ABDOMINAL	75625	323	4393.00
50110261	SI AORTOGM ABD W/RNF	75630	323	3564.00
50110337	SI ANGIO EXT UNI	75710	323	3357.00
50110345	SI ANGIO EXT BI	75716	323	4141.00
50110378	SI ANGIO ADD'L VESSEL	75774	323	1999.00
50110386	SI EMBOLIZATION	75894	320	5963.00
50110394	SI TRANSCTH INFUSION 75896	75896	320	2769.00
50110402	SI TRANSCATH ANGIO F/U 75898	75898	323	1438.00
50110444	SI PTA PERIPHERAL	75962	320	2303.00
50110451	PTA PERIPH ARTERY EA ADD 75964	75964	320	1872.00

Charge Code	Description	CPT Code	UB Revenue Code	Charge Amount
50110469	SI PTA RENAL/VISCERAL	75966	320	1872.00
50110477	SI PTA RENAL/VISCERAL ADD	75968	320	1872.00
50110519	CORONARY THROMBECTOMY	92973	480	3040.00
50110535	C1714 CATH,ARTHREC DIRECTIONAL	C1714	272	0.00
50110584	STENT, CAROTID	C1876	278	4200.00
50110592	EMBOSHIELD NAV 6 ABBT	C1884	272	2090.00
50110600	FILTERWIRE BSCI	C1884	272	1835.00
50110634	C1769 GUIDEWIRE, PCI, OE	C1769	272	0.00
50110642	C1769 GUIDEWIRE, DX, OE	C1769	272	0.00
50110659	C1894 SHEATH,CCL DX,OE	C1894	272	0.00
50110667	C1893 SHEATH,GUIDING,OE	C1893	272	0.00
50110709	CATH,CCL,OE		272	0.00
50110741	AORTOGRAM W/CATH 36200/75625	75625	323	4393.00
50110766	EXT ANGIO BILAT W/CATH	75716	323	989.00
50110790	EXT ANGIO UNILAT W/CATH	75710	323	989.00
50111061	THERMOSET		272	107.00
50111079	CABLES, PACING		272	58.00
50111178	PERICARDIAL WINDOW CREATE		360	1066.00
50111186	CAROTID STENT W/DISTAL PROTECT		360	5598.00
50111228	VENOUS RENIN SAMPLING	75893	320	978.00
50111244	VENOUS CATH SAMPLE		360	1152.00
50111251	RENAL ATHERECTOMY		360	3445.00
50111319	VSD CLOSURE	93581	481	17770.00
50111327	SI PTA AORTA	75966	320	1872.00
50111533	BALLOON PERIPHERAL 2	C1725	272	416.00
50112002	THROMBECTOM ART NONCOR INITIA		360	5525.00
50112010	THROMBECTOMY ART NONCOR ADD		360	2252.00
50112028	THROMBECT ART NONCOR NONPRIM		360	2252.00
50112036	THROMBECTOMY VENOUS INITIAL		360	6949.00
50112044	THROMBECT VENOUS REP SUBSEQL		360	6949.00
50112051	REPOSITION PREV CVP CATHETER		360	1353.00
50112069	INJECT EXIST VENOUS ACC DEVICE		360	30.00
50130012	INSERT AAA GRAFT STENT		360	3235.00
50130020	SI ENDO RPR AAA GRAFT STENT	75952	320	1170.00
50130046	INSERT NON TUNNEL CVC > 5YRS		360	2729.00
50130053	INSERT PICC LINE > 5 YRS		360	2015.00
50130061	3D RENDER W/POST PROCESS	76377	320	1119.00
50150002	RT HEART CATH	93451	481	9450.00
50150010	LHC W/WO LV INC S& I	93452	481	9450.00
50150028	RHC/LHC W/WO LV INC S&I	93453	481	9450.00
50150036	CORONARY ANGIO INC INJECT, S&I	93454	481	9450.00
50150044	COR ANGIO-GRAFT(S)	93455	481	9450.00
50150051	CORONARY ANGIO W/RHC	93456	481	9450.00
50150069	CORONARY ANGIO W/RHC GRAFTS	93457	481	9450.00
50150077	CORONARY ANGIO W/LHC AND LV	93458	481	9450.00
50150085	LHC W/WO LV COR GRAFT (S)	93459	481	9450.00
50150093	RHC/LHC W/WO LV COR	93460	481	9450.00
50150101	RHC/LHC W/WO LV COR GRAFT(S)	93461	481	9450.00
50150119	RA/RV ANGIOGRAPHY ADD ON	93566	481	870.00
50150127	AORTIC ROOT AOA ANGIO ADD ON	93567	481	870.00
50150135	PULMONARY ANGIOGRAPHY ADD ON	93568	481	870.00
50150143	CORONARY ANGIO (CONGENITAL) AI	93563	481	1451.00
50150150	GRAFT (S) ANGIO (CONGENITAL)AD	93564	481	1451.00
50150168	LA-LV ANGIO (CONGENITAL) ADD O	93565	481	1451.00
50150556	ATHERTOMY ILIAC EA VESL INC S&		360	9780.00

Charge Code	Description	CPT Code	UB Revenue Code	Charge Amount
50180165	CONSC SEDATION 30 MINS < 5YRS	99143	370	524.00
50180173	CONSC SEDATION 30 MINS > 5YRS	99144	370	524.00
50180181	CONSC SEDATION EA ADD 15 MINS	99145	370	288.00
50180223	EKG 12 LEAD	93005	730	284.00
50180272	ECHO TEE ANOMALY PROBE PLMNT	93316	480	555.00
50180314	REM IABP PERC 33968		360	516.00
50180322	INTRAVASC DOPP COLOR FLOW 1ST	93571	481	2630.00
50180330	INTRAVASC DOPP COLOR FLOW ADD	93572	481	1578.00
50180348	RX AGENT ADMIN W/CATH	93463	481	910.00
50180355	ILIAC REVASC UNILAT INC S&I		360	7890.00
50180363	ILIAC REVASC UNILAT W/STNT S&I		360	7890.00
50180371	ILIAC REVASC ADD ON 37220/3722		360	7890.00
50180389	ILIAC REVASC W/STNT ADD 37221		360	7890.00
50180397	FEM/POPL REVASC W/TLA		360	7890.00
50180405	FEM/POPL REVASC W/STNT S&I		360	17022.00
50180413	FEM/POPL REVASC STNT/ATHER		360	29479.00
50180421	TIB/PER REVASC W/TLA S&I		360	8018.00
50180439	TIB/PER REVASC W/ATHER S&I		360	17022.00
50180447	TIB/PER REVASC W/STNT S&I		360	17022.00
50180454	TIB/PER REVASC STNT/ATHER		360	29479.00
50180462	TIB/PER REVASC ADD ON		360	8018.00
50180470	TIB/PER REVASC ATHER ADD ON		360	17022.00
50180488	REVASC OPN/PRX TIB/PER STNT AD		360	8018.00
50180496	TIB/PER REVASC STNT/ ATHER		360	8018.00
50180504	FEM/POPL REVASC W/ATHER S&I		360	17022.00
50180512	ATHERTOMY RENAL INC S&I		360	9780.00
50180520	ATHERTOMY VISCERAL INC S&I		360	9780.00
50180538	ATHERTOMY ABD AORTA INC S&I		360	9780.00
50180546	ATHERTOMY BRACHCEPH EA VESS II		360	9780.00
50180553	PTCA LM	92920	480	8294.00
50180561	PTCA LC	92920	480	8294.00
50180579	PTCA RC	92920	480	8294.00
50180587	PTCA RI ADD VESSEL/BRNCH	92921	480	4684.00
50180595	PTCA LC ADD VESSEL/BRNCH	92921	480	4684.00
50180603	PTCA RC ADD VESSEL/BRNCH	92921	480	4684.00
50180611	ATHERECTOMY/PTCA LD	92924	480	18081.00
50180629	ATHERECTOMY/PTCA LC	92924	480	18081.00
50180637	ATHERECTOMY/PTCA RC	92924	480	18081.00
50180645	ATHERECTOMY/PTCA ADD RI	92925	480	12455.00
50180652	ATHERECTOMY/PTCA ADD LC	92925	480	12455.00
50180660	ATHERECTOMY/PTCA ADD RC	92925	480	12455.00
50180678	DRUG ELUTING STENT/PTCA LD	92928	480	22376.00
50180686	DRUG ELUTING STENT/PTCA LC	92928	480	22376.00
50180694	DRUG ELUTING STENT/PTCA RC	92928	480	22376.00
50180702	STENT /PTCA ADD RI VESSEL/BRNC	92929	480	11511.00
50180710	STENT/PTCA ADD LC VESSEL/BRNCH	92929	480	11511.00
50180728	STENT /PTCA ADD RCVESSEL/BRNCH	92929	480	11511.00
50180736	ATHERECT/PTCA/STENT LD	92933	480	19951.00
50180744	ATHERECT/PTCA/STENT LC	92933	480	19951.00
50180751	ATHERECT/PTCA/STENT RC	92933	480	19951.00
50180769	ATHERECT/DES/PTCA ADD LD	92934	480	17026.00
50180777	ATHERECT/DES/PTCA ADD LC	92934	480	17026.00
50180785	ATHERECT/DES/PTCA ADD RI	92934	480	17026.00
50180793	ATHERECT/STENT/PTCA GRAFT	92937	480	19951.00
50180801	ATHERECT/DES/PTCA ADD GRAFT	92938	480	17026.00

EHS -- List Of Charges For Cardiac Catheterization

Charge Code	Description	CPT Code	UB Revenue Code	Charge Amount
50180819	ATHERECT/STENT/PTCA AMI	92941	480	19951.00
50180827	ATHERECT/DES/PTCA CTO	92943	480	27642.00
50180835	PTCA RI	92920	480	8294.00
50180843	PTCA LD	92920	480	8294.00
50180850	PTCA LD ADD VESSEL/BRNCH	92921	480	4684.00
50180868	ATHERECTOMY/PTCA RI	92924	480	18081.00
50180876	ATHERECTOMY/PTCA LM	92924	480	18081.00
50180884	ATHERECTOMY/PTCA ADD LD	92925	480	12455.00
50180892	DRUG ELUTING STENT/PTCA LM	92928	480	22376.00
50180900	DRUG ELUTING STENT/PTCA RI	92928	480	22376.00
50180918	STENT/PTCA LD	92928	480	14796.00
50180926	STENT/PTCA LM	92928	480	14796.00
50180934	STENT/PTCA LC	92928	480	14796.00
50180942	STENT/PTCA RI	92928	480	14796.00
50180959	STENT/PTCA RC	92928	480	14796.00
50180967	DES/PTCA ADD LD VESSEL/BRNCH	92929	480	13503.00
50180975	DES/PTCA ADD RI VESSEL/BRNCH	92929	480	13503.00
50180983	DES/PTCA ADD RC VESSEL/BRNCH	92929	480	13503.00
50180991	DES/PTCA ADD LC VESSEL/BRNCH	92929	480	13503.00
50181007	STENT/PTCA ADD LD VESSEL/BRNCH	92929	480	11511.00
50181015	ATHERECT/PTCA/STENT RI	92933	480	19951.00
50181023	ATHERECT/PTCA/STENT LM	92933	480	19951.00
50181031	ATHERECT/DES/PTCA LD	92933	480	27642.00
50181049	ATHERECT/DES/PTCA RC	92933	480	27642.00
50181056	ATHERECT/DES/PTCA RI	92933	480	27642.00
50181064	ATHERECT/DES/PTCA LC	92933	480	27642.00
50181072	ATHERECT/DES/PTCA LM	92933	480	27642.00
50181080	ATHERECT//PTCA/STENT ADD RC	92934	480	16666.00
50181098	ATHERECT/PTCA/STENT ADD RI	92934	480	16666.00
50181106	ATHERECT//PTCA/STENT ADD LC	92934	480	16666.00
50181114	ATHERECT//PTCA/STENT ADD LD	92934	480	16666.00
50181122	ATHERECT/DES/PTCA ADD RC	92934	480	17026.00
50181130	ATHERECT/STENT/PTCA ADD GRAFT	92938	480	16666.00
50181148	ATHERECT/DES/PTCA AMI	92941	480	27642.00
50181155	ATHERECT/STENT/PTCA CTO	92943	480	19951.00
50181163	ATHERECT/DES/PTCA ADD CTO	92944	480	17026.00
50181171	ATHERECT/DES/PTCA GRAFT	92937	480	27642.00
50181189	ARCH CAROTID NON SELECT36221		360	4975.00
50181197	ARCHCAROTID CERVSELUNI 36222		360	8189.00
50181205	ARCHCAROTID COM SEL UNI 36223		360	7324.00
50181213	VERTEBRAL NON SEL UNI 36225		360	6556.00
50181221	FOREIGN BODY RETRIEVAL 37197		360	3695.00
50181239	THROMB INFUSN ART INIT 37211		360	3324.00
50181247	THROMB F/U W REPOST 37213		360	4267.00
50181254	ATHERECT/STENT/PTCA ADD CTO	92944	480	16666.00
50181262	36147 INTR NDL AV SHNT INIT FL		360	1418.00
50181270	36148 INTR CATH AV SHUNT THER		360	884.00
50190016	GUIDEWIRE, SPECIALTY	C1769	272	143.00
50190081	BIPOLAR PACING CATHETER		272	212.00
50190230	BALLOON TYSHAK	C1725	272	674.00
50190321	CATH, BERMAN ANGIO	C2628	272	304.00
50190388	CATH,DIAGNOSTIC DX-ALL		272	40.00
50190594	CATH, GUIDE SPECIAL	C1887	272	245.00
50191063	CATH WEDGE PRESSURE MONITOR	C2628	272	116.00
50191238	FORCEPS,BIOPSY		272	636.00

Charge Code	Description	CPT Code	UB Revenue Code	Charge Amount
50191568	GUIDEWIRE, ALL DX	C1769	272	42.00
50191592	GUIDEWIRE,WHOLEY	C1769	272	149.00
50191741	CNTRST OMNIPQUE PER ML 200	Q9967	255	2.00
50191790	SHEATH, DIAGNOSTIC	C1894	272	38.00
50191808	SHEATH INTRDUCER CAROTID C1894	C1894	272	225.00
50191816	SHEATH INTRDUCER RADIAL C1894	C1894	272	125.00
50191824	SHEATH GUIDING	C1893	272	125.00
50191907	TRAY,CARDIAC CORONARY		272	149.00
50192194	BALLOON,BSCI PCI-ALL	C1725	272	416.00
50192293	CONTRST VISPAQUE PERML 150	Q9967	255	2.00
50192319	CONTRST VISPAQUE PER ML 50	Q9967	255	2.00
50193002	C1887 CATH GUIDE OE	C1887	272	0.00
50193028	C1725 BALLOON CORONARY OE	C1725	272	0.00
50193036	C1725 BALLOON PERIPHERAL OE	C1725	272	0.00
50193044	SUPPLY,OE MEDSURG CCL		270	0.00
50193069	ATRIAL SEPTOSTOMY (BLADE)	92993	480	5783.00
50193077	ATRIAL SEPTOSTOMY (BALLOON)	92992	480	5783.00
50193085	CATH,THROMBECTOMY	C1757	272	1112.00
50193093	CATHETER,EXCHANGE		272	456.00
50193101	LUBRICANT,ROTOGLIDE		272	155.00
50193119	SLED,IVUS PULLBACK		272	115.00
50193127	C1874 STENT COATED/COV W/DEL	C1874	278	0.00
50193135	C1876 STENT,BARE METAL, O.E.	C1876	278	0.00
50193143	CATH PIGTAIL MARKER		272	231.00
50193150	CARDIAC DES- RESEARCH	C1874	278	1.00
50193168	CATHETER CTO EXCHANGE	C1725	272	1272.00
50193176	STENT, PCI BM-2	C1876	278	1190.00
50193184	IMPLANT DEVICE CREDIT		278	0.00
50193226	STENT VIABAHN	C1874	278	6370.00
50193242	C1817 SEPTAL OCCLUDER OE	C1817	278	0.00
50193259	CNTRST OMNIPQUE PER ML 50	Q9967	255	2.00
50193275	CATHETER, OUTBACK RE-ENTRY		272	2741.00
50193283	CATHETER, ATHRECTOMY SILVERHW	C1714	272	3368.00
50193291	C1877 STENT UNMOUNTED OE	C1877	278	0.00
50193309	AMPLATZER PDA OCCLUDER DEVICE	C1760	278	3600.00
50193325	BALLOON SEPTOSTOMY	C1725	272	476.00
50193333	SHEATH RETRIEVAL	C1773	272	158.00
50193341	SEL CATH PLCMT,ABD/PEL 3RD ORD		360	179.00
50193358	IVC FILTER INSERT INC S&I		360	6401.00
50193366	IVC FILTER REPOS INC S&I		360	4394.00
50193374	IVC FILTER REMOVAL INC S&I		360	4394.00
50193382	ANGIO RENAL ACC 1ST ORD UNI		360	3492.00
50193390	ANGIO RENAL 36252 1ST ORD BIL		360	3492.00
50193408	ANGIO RENAL ACC 2ND ORD UNI		360	5408.00
50193416	ANGIO RENAL ACC 2ND ORD BIL		360	5408.00
50193424	CARDIOVASC STRESS TEST TRACINC	93017	482	1155.00
50193432	ENDOVAS GRFT REPL ILIAC ART S&	75954	320	1113.00
50193440	INSERT ILIAC GRAFT STNT 34900		360	2250.00
50193457	ENDOVAS GRFT EXT PLACE S&I	75953	320	1170.00
50193465	INSERT EXTENSION GRAFT 34825		360	3500.00
50193473	STNT RENAL/VISC W/WO PTA 37236	37236	360	13678.00
50193481	STNT REN/VIS W/WOPTA ART 37237	37237	360	6615.00
50193499	EMBOL OCCLUDE ARTERY 37242	37242	360	15252.00
50193507	PDA CLOSURE 93582	93582	480	19180.00
50193515	ARCH/CAROTID CERVSEL BIL 36222		360	9500.00

Charge Code	Description	CPT Code	UB Revenue Code	Charge Amount
50193523	ARCH/CAROTID COMSEL BIL 36223		360	9500.00
50193549	VERTEBRAL BIL 36225		360	9500.00
50193556	TEE FOR GUIDANCE	93355	483	
50193564	RHC W/PA PRESS MONTOR IMPLNT	C9741	481	
50199017	CATHETER IVUS CLIN TRIAL	C1753	272	1.00
50199025	NEEDLE, SMART DOPPLER		272	175.00
50199033	AMPLATZER VASCULAR PLUG		278	1600.00
50199041	GLIDESHEATH KIT	C1894	272	160.00
50199058	CATHETER MICRO GUIDE XP	C1887	272	400.00
50199066	CATHETER CTO FRONTRUNNER XP	C1725	272	1640.00
50199082	WIRE PRESSURE/FFR	C1769	272	1200.00
50199108	CATHETER IVUS PERIPHERAL	C1753	272	1540.00
50199116	STENT DES PROMUS ELEMENT BSCI	C1874	278	3010.00
50199124	OSTIAL PRO POSITIONING DEVICE		272	1200.00
50199132	STENT DES ENDEAVOR	C1874	278	2750.00
50199157	STENT, ZILVER PTX DES	C1874	278	3590.00
50199165	ZENITH FENESTRATED GRFT OE		278	0.00
50199173	C1760 CLOSRE DEV VASC IMPLNT	C1760	278	0.00
50199181	C1874 STENT DES RESOLUTE	C1874	278	2750.00
50199199	C1725 BALLN STINGRAY CTO	C1725	272	1690.00
50199207	C1769 WIRE, SPECIALTY 2	C1769	272	330.00
50199215	C1725 CATHETER, CROSSBOSS CTO	C1725	272	1400.00
50199223	CARDIO MEMS PA SENSR DEVICE	C2624	278	

Erlanger Health System -- Other Expenses

		2012	2013	2014
Purchased Services		102,702,749	111,584,374	114,459,641
Utilities		9,757,309	9,736,115	10,012,328
Drugs		32,551,755	32,921,513	39,370,552
Insurance and Taxes		4,467,158	2,198,654	2,723,124
Purchased Services		**102,702,749**	**111,584,374**	**114,459,641**
620142	Restricted Fund Expense	237,126	76,633	117,502
620252	Physician Fees	20,113,740	20,510,257	20,661,564
620302	Consulting	1,668,100	8,018,102	1,421,495
620322	Legal Fees	1,869,626	2,393,527	3,057,657
620332	Audit Fees	211,360	194,406	189,312
620352	Architect & Eng Fees	123,174	182,585	360,654
620492	Time & Mat Contract	3,659,430	3,023,421	4,101,893
620502	Dietary	516,296	621,402	685,028
620522	Unscheduled Maint	3,374,335	4,687,799	5,182,758
620010	Plz Surgery Minority Interesy	-149,843		
620523	CUC Delivery/Vehicle Expense	31,248	32,607	17,732
620532	Advertising	2,198,138	2,555,479	2,490,627
620542	Purchased Services	31,214,122	29,055,253	31,846,157
620562	Purchased Maint	3,908,269	3,220,291	4,115,060
620572	Freight Charges	275,027	314,512	293,794
620573	CUC Penalties	2,561	1,425	
620574	CUC Late Fees	2,000	4,971	7,378
620582	Collection Fees	162,324	738,913	904,813
620602	Lab Outside Fees	3,709,926	3,205,690	3,257,673
620622	Computer Services	4,501,692	4,970,519	5,156,385
620682	Micro Maint	95,567	74,128	60,533
620692	Equipment Rental	3,246,154	3,033,690	3,605,722
620792	Contracted Services	15,797,297	18,663,071	20,802,740
620892	Membership & Dues	1,398,184	1,167,871	948,989
620902	Special Classes	10,365	27,957	45,251
620912	Licenses & Fees	1,175,538	1,281,524	1,379,705
620922	Development Costs	45,716	176,338	406,179
620932	Professional Education	1,059,982	1,045,961	1,161,763
620933	CUC Meals & Entertainment	9,910	11,491	1,291
620952	Local Travel	315,197	323,282	287,345
620953	CUC Field Trip Expense	9,764	12,657	23,799
620982	Business Courtesy	34,226	44,274	13,444
621182	Asbestos Expense	31,350	128,761	63,639
621202	Recruiting	634,222	670,202	824,569
621272	Resident Education	311,609	295,055	295,284
621532	Public Relations	474,619	487,507	271,427
621972	Patient parking	186,556	217,813	213,034
622002	Med/Prof Housing Expense	237,841	115,000	187,444
Utilities		**9,757,309**	**9,736,115**	**10,012,328**
640702	Billed Utilities	-412,326	-461,257	-576,458
640712	Electricity	6,111,788	5,927,593	6,124,308
640722	Gas	1,552,861	1,559,592	1,848,971
640732	Water	1,050,175	1,136,971	1,195,584
640742	Oil	10,816	6,450	19,507
640752	Storm Water Fees	53,048	39,551	43,267
640882	Telephone	1,390,947	1,527,215	1,357,149
Drugs		**32,551,755**	**32,921,513**	**39,370,552**
630403	Drugs	32,551,755	32,921,513	39,370,552
Insurance and Taxes		**4,467,158**	**2,198,654**	**2,723,124**
670847	Self Insurance Expense	1,686,257	952,825	704,755
670857	Insurance	2,695,711	1,207,188	1,971,569
680878	CUC Taxes - Sales	11,966	629	178
680880	Gross Receipts Tax	73,224	38,012	46,622

Department	Organization	Contracting Entity	Vendor (Other Party)	Contract No.	Contract Type	Effective Date	Expiration Date	Description
7157 - Renal Transplant Donor	Erlanger Health System	Erlanger Health System	Sweetwater Dialysis Center	2002.4290C	Patient Transfer Agreement	6/19/2009	Evergreen	Provide Renal Transplantation and other services to Clinic patients
7157 - Renal Transplant Donor	Erlanger Health System	Erlanger Health System	Harbin Clinics LLC	2002.4420C	Patient Transfer Agreement	10/16/2012	10/15/2015	Renal Transplant Patient Transfer
7158 - Renal Transplant Administration	Erlanger Health System	Erlanger Health System	Dialysis Clinic, Inc	2002.1508C	Patient Transfer Agreement	3/23/1998	Evergreen	DCI Patient Transfer Agreements (all facilities -- see attachments)
7158 - Renal Transplant Administration	Erlanger Health System	Erlanger Health System	Rhea County Medical Center	2002.1636C	Patient Transfer Agreement	9/1/1989	Evergreen	Renal Transplant Services (Transfer)
7158 - Renal Transplant Administration	Erlanger Health System	Erlanger Health System	Chattanooga Kidney Centers, LLC and Chattanooga Kidney Centers 58, LLC and Chattanooga Kidney Centers North, LLC and Kidney Center of Missionary Ridge	2002.4023C	Patient Transfer Agreement	10/10/2011	10/9/2015	Renal Transplant Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Kindred Hospital	2002.707C	Patient Transfer Agreement	10/1/2001	Evergreen	Patient Transfer Agreement

Department	Organization	Contracting Entity	Vendor (Other Party)	Contract No.	Contract Type	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Life Care Center of Collegedale	2002.1292C	Patient Transfer Agreement	1/1/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Marshall Medical Center North	2002.1293C	Patient Transfer Agreement	2/1/2000	Evergreen	Pediatric Patient Transfer
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Life Care Center of Red Bank	2002.1294C	Patient Transfer Agreement	1/1/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Tender Loving Care	2002.1306C	Patient Transfer Agreement	1/1/1995	Evergreen	Hospice Transfer
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	LaFayette Health Care	2002.1317C	Patient Transfer Agreement	1/31/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Jefferson Memorial Hospital	2002.1321C	Patient Transfer Agreement	10/22/2004	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Mountain Creek Manor	2002.1336C	Patient Transfer Agreement	1/20/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Murphy Medical Center	2002.1337C	Patient Transfer Agreement	4/1/2000	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Northside Hospital	2002.1342C	Patient Transfer Agreement	4/10/1992	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Renaissance Rehabilitation	2002.1363C	Patient Transfer Agreement	4/26/1990	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Rivermont Convalescent Center	2002.1372C	Patient Transfer Agreement	1/25/1995	Evergreen	Patient Transfer
8028 - Patient	Erlanger Heal	Erlanger Heal	The Health C	2002.1384C	Patient Transf	6/18/2012	6/17/2015	Patient Transf

Department	Organization	Contracting Entity	Vendor (Other Party)	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Logistics	th System	th System	enter at Standifer Place		er Agreement			er
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Shepherd Hills Health Care Center	2002.1385C	Patient Transfer Agreement	1/25/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Methodist Medical Center	2002.1388C	Patient Transfer Agreement	2/6/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Brookewood Medical Center	2002.1389C	Patient Transfer Agreement	6/27/2012	6/26/2015	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Continuum Care Corporation d/b/a Spring City Health Care Center	2002.1390C	Patient Transfer Agreement	2/1/1999	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Bledsoe Community Medical Center	2002.1430C	Patient Transfer Agreement	6/27/2012	6/26/2015	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	The University of Tennessee Medical Center	2002.1446C	Patient Transfer Agreement	5/29/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Erlanger Bledsoe	2002.1461C	Patient Transfer Agreement	10/1/2001	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Cookeville Regional Medical Center	2002.1483C	Patient Transfer Agreement	2/10/2010	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Scott County Hospital	2002.1498C	Patient Transfer Agreement	1/11/2001	Evergreen	Patient Transfer Agreement

Department	Organization	Contracting Entity	Vendor (Other Party)	Contract No.	Contract Type	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Wellmont Health Systems	2002.1499C	Patient Transfer Agreement	6/30/2001	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Laughlin Memorial Hospital, Inc	2002.1502C	Patient Transfer Agreement	11/23/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Fort Sanders Park West Medical Center	2002.1539C	Patient Transfer Agreement	10/22/1999	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Johnson City Medical Center	2002.1550C	Patient Transfer Agreement	5/29/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Life Care Center of Chattanooga	2002.1576C	Patient Transfer Agreement	1/25/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	St Barnabas Nursing Home	2002.1594C	Patient Transfer Agreement	1/25/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	North Jackson Hospital	2002.1599C	Patient Transfer Agreement	2/1/2000	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	National Health Care of Rossville	2002.1605C	Patient Transfer Agreement	5/17/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	National Health Care of Fort Oglethorpe	2002.1606C	Patient Transfer Agreement	5/22/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	National Healthcare of Dunlap	2002.1607C	Patient Transfer Agreement	6/20/2012	6/19/2015	Patient Transfer Agreement

Department	Organization	Contracting Entity	Vendor (Other Party)	Contract No.	Contract Type	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	National Health Care of Athens	2002.1608C	Patient Transfer Agreement	5/15/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Shriners Hospitals for Children	2002.1623C	Patient Transfer Agreement	7/1/2000	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Rhea Medical Center	2002.1634C	Patient Transfer Agreement	2/6/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Siskin Hospital for Physical Rehabilitation	2002.1650C	Patient Transfer Agreement	2/9/1990	Evergreen	Shared Services
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Alexian Village of Chattanooga	2002.1670C	Patient Transfer Agreement	1/1/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Blount Memorial Hospital	2002.1685C	Patient Transfer Agreement	2/7/2001	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Columbia Indian Path Medical Center	2002.1714C	Patient Transfer Agreement	1/13/1997	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Columbia East Ridge Hospital	2002.1715C	Patient Transfer Agreement	3/31/1998	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	East Ridge Hospital	2002.1716C	Patient Transfer Agreement	10/22/1996	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	NovaMed Eye and Laser Surgery, Center of	2002.1717C	Patient Transfer Agreement	6/27/2002	Evergreen	Patient Transfer Agreement

Department	Organization	Contracting Entity	Vendor (Other Party)	Contract No.	Contract Type	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Jamestown Regional Medical Center, f/k/a Fentress County Hospital	2002.1750C	Patient Transfer Agreement	5/14/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Healthsouth Chattanooga Surgery Center	2002.1766C	Patient Transfer Agreement	4/13/1999	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	St Mary's Health System, Inc	2002.2377C	Patient Transfer Agreement	4/1/2003	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Redmond Regional Medical Center	2002.2697C	Patient Transfer Agreement	1/17/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Murray Medical Center	2002.2699C	Patient Transfer Agreement	12/5/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Medical Center of Manchester	2002.2700C	Patient Transfer Agreement	4/19/2012	4/18/2015	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Lincoln County Health System	2002.2702C	Patient Transfer Agreement	11/30/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Fannin Regional Hospital	2002.2704C	Patient Transfer Agreement	6/18/2012	6/17/2015	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Cumberland Medical Center, Inc	2002.2706C	Patient Transfer Agreement	12/2/2011	Evergreen	Patient Transfer
8028 - Patient	Erlanger Heal	Erlanger Heal	Copper Basin	2002.2707C	Patient Transf	12/1/2011	Evergreen	Patient Transf

Department	Organization	Contracting Entity	Vendor (Other Party)	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Logistics	th System	th System	Medical Center		er Agreement			er Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Highlands Medical Center	2002.2777C	Patient Transfer Agreement	4/25/2012	12/31/2015	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Gordon Hospital	2002.2830C	Patient Transfer Agreement	7/1/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Chattanooga Rehabilitation Hospital	2002.2854C	Patient Transfer Agreement	7/25/2012	7/24/2015	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Vanderbilt University Medical Center	2002.4049C	Patient Transfer Agreement	7/1/2008	Evergreen	Burn Patient Transfer
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Physician Surgery Center of Chattanooga	2002.4234C	Patient Transfer Agreement	4/2/2012	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Parkridge Medical Center	2002.4267C	Patient Transfer Agreement	5/18/2012	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Eye Surgery Center of Chattanooga	2002.4833C	Patient Transfer Agreement	10/23/2014	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	Erlanger Health System	Renaissance Surgery Center	2002.5425C	Patient Transfer Agreement	2/16/2012	Evergreen	Patient Transfer Agreement
8413 - Disaster Management & EOC	Erlanger Health System	Erlanger Health System	East Tennessee Regional Hospitals	2002.6387C	Patient Transfer Agreement	10/10/2014	Evergreen	Disaster Aid Agreement (Memorial Health Care; Parkridge Medical Center, Inc ; Southern Te

Department	Organization	Contracting Entity	Vendor (Other Party)	Contract No.	Contract Type	Effective Date	Expiration Date	Description
								nnessee Medical Center (Winchester & Sewanee); Copper Basin Medical Center; Star Regional Medical Center-(Athens & Etowah); Rhea Medical Center; Skyridge Medical Center)

Board for Licensing Health Care Facilities

State of Tennessee

DEPARTMENT OF HEALTH

No. of Beds 0000000140 0768

This is to certify, that a license is hereby granted by the State Department of Health to

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY to conduct and maintain a

Hospital ERLANGER MEDICAL CENTER

Located at 975 EAST THIRD STREET, CHATTANOOGA

County of HAMILTON, Tennessee.

This license shall expire JUNE 04, 2015, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State this 4TH day of JUNE, 2014.

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC OPRC HOSPITAL
TRAUMA CENTER LEVEL 1

By _____, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By _____, MD
COMMISSIONER

DCH013

The Joint Commission

July 8, 2014

Re: # 7809
CCN: #440104
Program: Hospital
Accreditation Expiration Date: April 05, 2017

Kevin M. Spiegel
President and CEO
Erlanger Health System
975 East Third Street
Chattanooga, Tennessee 37403

Dear Mr. Spiegel:

This letter confirms that your March 31, 2014 - April 04, 2014 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on June 20, 2014 and June 27, 2014 and the successful on-site Medicare Deficiency Follow-up event conducted on May 19, 2014, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of April 05, 2014. We congratulate you on your effective resolution of these deficiencies.

§482.12 Governing Body
§482.41 Physical Environment
§482.42 Infection Control

The Joint Commission is also recommending your organization for continued Medicare certification effective April 05, 2014. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Academic Internal Medicine and Endocrinology
979 E. Third Street, Suite B-601, Chattanooga, TN, 37403

Academic Gastroenterology
979 East Third Street, Suite C-825, Chattanooga, TN, 37403

Academic Urologist at Erlanger
979 East Third Street, Suite C - 535, Chattanooga, TN, 37403

Alton Park (Southside) Community Health Center
100 East 37th Street, Chattanooga, TN, 37410

Dodson Avenue Community Health Center
1200 Dodson Avenue, Chattanooga, TN, 37406

Erlanger Academic Urologists
1755 Gunbarrel Road, Suite 209, Chattanooga, TN, 37421

Erlanger at Volkswagon Drive Wellness Center
7380 Volkswagon Drive, Suite 110, Chattanooga, TN, 37416

Erlanger East Family Practice
1755 Gunbarrel Road, Suite 201, Chattanooga, TN, 37421

Erlanger East Imaging
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - East Campus
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - Main Site
975 East Third Street, Chattanooga, TN, 37403

Erlanger Health System - North Campus
632 Morrison Springs Road, Chattanooga, TN, 37415

Erlanger Hypertension Management Center
979 East Third Street, Suite B601, Chattanooga, TN, 37403

Erlanger Metabolic and Bariatric Surgery Center
979 E. Third Street Suite C-620, Chattanooga, TN, 37403

Erlanger Neurology/Southeast Regional Stroke Center
979 East Third Street, Suite C830, Chattanooga, TN, 37403

Erlanger North Family Practice, Neurobehavioral & Memory Svs
632 Morrison Springs Road, Suite 202, Chattanooga, TN, 37415

Erlanger North Sleep Medicine and Neurology
632 Morrison Springs Road, Suite 300, Chattanooga, TN, 37415

Erlanger South Family Practice
60 Erlanger Drive, Suite A, Ringgold, GA, 30736

Erlanger Specialty Care for OB and Peds
1504 North Thornton Avenue, Suite 104, Dalton, GA, 30720

Hypertension Management - Chattanooga Lifestyle Center
325 Market Street, Suite 200, Chattanooga, TN, 37401

Life Style Center - Cardiac Rehab
325 Market Street, Chattanooga, TN, 37401

Ortho South
979 East Third Street suite C 430, Chattanooga, TN, 37403

Southern Orthopaedic Trauma Surgeons
979 East Third Street Suite C-225, Chattanooga, TN, 37403

TCT Cardiology/GI/Genetics
910 Blackford Street - 3rd Fl Massoud, Chattanooga, TN, 37403

TCT Children's Subspecialty Center
2700 West Side Drive, Cleveland, TN, 37312

TCT Endocrine
910 Blackford, 1st fl Massoud, Chattanooga, TN, 37403

TCT Hematology/Oncology
910 Blackford Street - 5th fl Massoud Bl, Chattanooga, TN, 37403

TCT Nephrology
910 Blackford St, Ground Level, TCTCH, Chattanooga, TN, 37403

University Health Obstetrics & Gynecology
979 East Third Street, Suite C-725, Chattanooga, TN, 37403

University Medical Assoc
960 East Third Street, Whitehall Building, Suite 208, Chattanooga, TN, 37403

University Orthopedics
979 East Third Street, Suite C-220, Chattanooga, TN, 37403

University Pediatrics
910 Blackford Street - Gr floor Massoud, Chattanooga, TN, 37403

University Pulmonary and Critical Care
979 East Third Street, Suite C 735, Chattanooga, TN, 37403

University Rheumatology Associates
979 East Third Street, Suite B-805, Chattanooga, TN, 37403

UT Dermatology
979 East Third Street, - Suite 425 A - Med Mall, Chattanooga, TN, 37403

UT Erlanger Cardiology
975 East Third Street, Suite C-520, Chattanooga, TN, 37403

UT Erlanger Cardiology East
1614 Gunbarrel Road, Ste 101, Chattanooga, TN, 37421

Ut Erlanger Health & Wellness@Signal Mtn
2600 Taft Highway, Signal Mountain, TN, 37377

UT Erlanger Lookout Mtn Primary Care
100 McFarland Road, Lookout Mountain, GA, 30750

UT Erlanger Primary and Athletic Health
1200 Pineville Road, Chattanooga, TN, 37405

UT Family Practice
1100 East Third Street, Chattanooga, TN, 37403

Workforce at UT Family Practice
1100 East 3rd Street, Chattanooga, TN, 37403

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR QUALITY IMPROVEMENT
AND SURVEY & CERTIFICATION OPERATIONS

Reference M:2014,Erlanger.Med.Ctr.440104.Co.No.33779.11.18.14.accept.poc

December 8, 2014

Mr. Kevin Spiegel, CEO
Erlanger Health System
975 E. 3rd Street
Chattanooga, Tennessee 37403

RE: Erlanger Health System
CMS Certification Number (CCN) 44-0104
EMTALA Complaint Control Number: TN00033779

Dear Mr. Spiegel:

I am pleased to inform you that the plan of correction for *Erlanger Medical Center Hospital* has been reviewed and found to be acceptable.

When the Tennessee State Agency has determined that the noncompliance with EMTALA requirements has been corrected during their revisit, CMS will withdraw its current termination action. Failure to correct the deficient practice by February 16, 2014, will result in the termination of your Medicare provider agreement.

A copy of this letter is being forwarded to the Tennessee State Agency.

We thank you very much for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. Please contact our office if you have any questions and speak with Rosemary Wilder at 404-562-7452 or email: rosemary.wilder@cms.hhs.gov.

Sincerely yours,

Sandra M. Pace
Associate Regional Administrator

cc: North Carolina State Agency

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/18/2014
FORM APPROVED
OMB NO. 0938-0391

Final

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440104	A. BUILDING _____ B. WING _____	C 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERLANGER MEDICAL CENTER	975 E 3RD ST CHATTANOOGA, TN 37403

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A 000	INITIAL COMMENTS On May 13, 2014, investigation of EMTALA complaint TN-33779 was completed. Erlanger Medical Center was found out of compliance with Requirements for the Responsibilities of Medicare Participating Hospitals in Emergency Cases 42 CRT Part 489.20 and 42 CFR 489.24. The administrator was notified via overnight mail on November 18, 2014 that a 90 day termination track would be imposed. The termination date is February 16, 2015.	A 000		
A2400	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on medical record review, review of facility policy, review of Medical Staff Rules and Regulations, and interview, the facility failed to provide appropriate transfers for four patients (#7, #8, #9, and #11). The findings included: Refer to A-2401 for failure to report receipt of an inappropriate transfer. Please refer to A-2402 for failure to conspicuously post signs. Please refer to A-2409 for failure to provide appropriate transfer.	A2400	A2400: 489.20(l) Compliance with 289.24 **The findings included:** This STANDARD is not met as evidenced by : based on Medical Record review, review of facility policy, review of medical staff rules and regulations, and interview, the facility failed to provide appropriate transfers for 4 patients (#7, #8, #9, and #11). **Plan of Correction Responsibility:** The Chief Medical Officer and the Chief of Emergency Medicine is responsible for the corrective action plan and ongoing compliance. **When/How Corrected:** See A2401 section and A2402 for corrective action plans. **Improvement to the Process** See A2401 section and A2402 for corrective action plans. **Education:** A2401 section and A2402 for corrective action plans.	
A2401	489.20(m) RECEIVING AN INAPPROPRIATE TRANSFER [The provider agrees,] in the case of a hospital as	A2401		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tawra Ray, CNE | TITLE: Chief Nurse Executive | (X6) DATE: 12/4/14

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ...ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...ogram participation.

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A2401	Continued From page 1 defined in §489.24(b), to report to CMS or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of §489.24(e). This STANDARD is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to report receipt of a patient transferred in an unstable emergency medical condition from the facility's East campus (Hospital #1) to the hospital's primary location (main campus - Hospital #2), a distance of 10.2 miles, for one patient (#7) of sixteen patients reviewed. The findings included: Review of facility policy titled "Transfers...PC.074" most recently revised in February, 2012, revealed, "...To establish guidelines for transferring patient within a facility, to an alternative level of care, or to another acute care facility while assuring medically appropriate continuity of care and compliance with EMTALA (Emergency Medical Treatment and Active Labor Act) regulation...The transferring physician determines the method of patient transport and the amount of support that will be needed during transport..." Review of a policy titled "(Facility) East Emergency Services Scope of Services" revealed, "Origination Date: 3/14" and the approval date was blank, indicating it had not been approved by the Medical Staff or the Governing Body.	A2401	A2401: 489.20(m) Receiving an Inappropriate Transfer **The findings included:** This STANDARD is not met as evidenced by: based on Medical Record review, review of facility policy, and interview, the facility failed to report receipt of a patient transferred in an unstable emergency medical condition from the facility Erlanger East Campus (Hospital #1) to the Hospitals' primary location (Main Campus- Hospital #2), a distance of 10.2 miles, for one patient #7 of 16 patients reviewed. **Plan of Correction Responsibility:** The Chief Medical Officer and the Chief of Emergency Medicine is responsible for the corrective action plan and ongoing compliance. **When/How Corrected:** Hospital # 1 is within the Erlanger Health System; however this was not reflected in the EMTALA Transfer Policy and **is now reflected in the policy draft. A new** system wide policy was developed to reflect this language and inclusion of current EMTALA and associated State law. The draft of this policy was reviewed by the Medical Executive Committee on December 1, 2014. The committee reviewed the policy and requested additional information. The final draft will be approved by the Medical Executive Committee on January 5, 2015. (See attachment # 1 - Draft EMTALA Transfer Policy) (See attachment # 7 – Medical Staff Executive Committee Meeting Agenda)	12/1/2014 1/5/2015

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A2401	Continued From page 2 Review of facility policy for the hospital's main campus titled "Emergency Department Scope of Services Number: EMS.280" most recently revised in March, 2010, revealed, "...An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of prompt and appropriate medical attention could result in...placing the health or safety of the patient or unborn child in serious jeopardy...The following conditions are declared to be emergency conditions by statute and regulation ...pregnancy with contractions present...Evaluation, management, and treatment of patients is appropriate and expedient...Immediate evaluation and stabilization, to the degree reasonably possible, will be available for each patient who presents with an emergency medical condition...Patients are to be transported to the nearest appropriate ED (emergency department) in accordance with applicable laws, regulations, and guidelines...All transfers will comply with local, state, and federal laws..." Review of an Emergency Room Log dated April 2, 2014, revealed Patient #7 presented to the facility's East campus with complaint of Vaginal Bleeding. Medical record review of a Triage note dated April 2, 2014, revealed, "...(6:37 a.m.) Complaint: Vaginal bleeding...(6:49 a.m.) Pain level 9 (0-10)...Quality is cramping. Since yesterday...states...is a 'couple weeks pregnant'...had a miscarriage in Jan (January) LMP (Last Menstrual Period): 11-15-2013 (history of five pregnancies, three delivered pregnancies)..."	A2401	**The Emergency Services Scope of Services policies (EMS #280 and EEED #7174.100) were reviewed and approved to include documentation of approval by the Chief of Emergency Medicine, and revision of the staffing model for Erlanger Baroness Campus. These policies are departmental policies that are required by all departments explaining the scope of the services the department provides, staffing for the department, special equipment and procedures.** **(See attachment #2 and #10.)** A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. (See attachment #4) **Education:** **Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.**	11/24/2014 12/5/2014 12/31/2014

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A2401	Continued From page 3 Medical record review of a history and physical dated April 2, 2014, at 7:14 a.m., revealed, "pt (patient) w/ (with) abd (abdominal) pain. lmp (last mentrual period) 11/5/13. thought she had miscarriage in January due to heavy bleeding and passing tissue. Was told last week that she is pregnant again. now having severe cramps. had some light bleeding past 2 days. today no bleeding but severe cramps. vomit x (times) 2. no diarrhea. no urinary sx (symptoms). no fever...Sudden onset of symptoms, Symptoms are worsening, are constant. Maximum severity of symptoms severe, Currently symptoms are severe. In my professional medical judgment...this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that in the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ...(7:18 a.m.) Abdominal exam included findings of abdomen tender, to the left upper quadrant, to the left lower quadrant, to the right lower quadrant, moderate intensity, no distension, firm uterus at umbilicus...Medical History...miscarriage x 2...cesarean section..." Medical record review of a physician's progress note dated April 2, 2014, at 7:20 a.m., revealed, "...BSUS (Bedside Ultrasound) shows IUP (Intrauterine Pregnancy) at approx 20 wks (approximately 20 weeks). Will obtain formal us (ultrasound), labs, and ob (obstetric) consult..." Medical record review of the Nursing Assessment: Continuing Assessment dated April	A2401	**Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East**. A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved, Results will be reported to the Erlanger Health System Quality Oversight Committee.	1/2015-4/1015

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A2401	Continued From page 4 2, 2014, revealed, "...(7:24 a.m.) per pt she miscarried in January at home and was never seen by OBGYN (Obstetrician/Gynecologist) to confirm. Pt sts (states) she was seen by OBGYN recently, but could not give specific day or date, and was told her blood pregnancy test was positive. Pt sts she is 'a couple of weeks pregnant'...patient appears, restless, uncomfortable...(7:40 a.m.) pt rates pain 8 on a scale of 1-10. MD notified new medication order received...(8:12 a.m.) States worsening pain, pt still c/o pain an 8 on a scale of 1-10. MD notified and new medication order received...Patient appears restless, uncomfortable...(8:56 a.m.) States decreased pain, Patient states decreased pain, although she still rates it 7 out of 10. She is not as restless and seems in no pain distress at this time. pain is more intermittent at this time... (9:10 a.m.) States worsening pain...Patient appears, uncomfortable..." Medical record review of a physician's note dated April 2, 2014, at 8:53 a.m., revealed, "Diagnosis Final: Primary Preterm Labor." Medical record review of a nurse's note dated April 2, 2014, at 8:54 a.m., revealed, "Ambulance service contacted...Estimated time of arrival 15-20 min (minutes)." Medical record review of a nurse's note dated April 2, 2014, at 9:06 a.m., revealed, "Indocin (medication to delay labor) ordered by (Medical Doctor - M.D. #1). Pharmacy called and we do not carry that medication on this campus. MD (MD #1) aware, medication order canceled." Medical record review of a nurse's note dated April 2, 2014, at 9:14 a.m., revealed, "Transfer:	A2401	**Indocin is now stocked at the Erlanger East campus pharmacy and available – Indomethacin dosage = 25mg x2 (50mg) PO stat then 25mg PO every 6 hours. Magnesium and Terbutaline are also available if requested.**	12/5/2014

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A2401	Continued From page 5 Reason for transfer need for specialized care, Diagnosis: preterm labor, Accepting Institution: (Hospital #2) Labor and Delivery, Accepting physician (M.D. #2)...Report called to receiving facility..." Medical record review of a Transfer Authorization dated April 2, 2014, at 9:18 a.m., revealed, "STABILITY The patient is stabilized at the time of transfer and no medical deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from this facility, or, with respect to a pregnant woman having contractions, the woman has delivered (including the placenta) OR The Patient is in a state of an emergency medical condition, and I hereby certify that based upon the information available to me at this time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility, outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer..." Review of the Transfer Authorization revealed both statements were checked. Further review revealed, "...appropriate transport service...Advanced...The receiving facility has agreed to accept the patient...Facility (Hospital #2)...accepting physician (M.D. #2)..." Continued review revealed, "...Reason for transfer: preterm labor Risk of transfer: death by MVC (motor vehicle crash) Benefits of transfer: higher level of care..." Medical record review of a physician's progress note dated April 2, 2014, at 9:22 a.m., revealed, "formal us (ultrasound) shows (20 week intrauterine pregnancy) and incompetent cervix. Discussed results (with M.D. #2 - patient's	A2401	**Indocin is now stocked at the Erlanger East campus pharmacy and available – Indomethacin dosage = 25mg x2 (50mg) PO stat then 25mg PO every 6 hours. Magnesium and Terbutaline are also available if requested.** 12/5/2014 Hospital # 1 is within the Erlanger Health System; however this was not reflected in the EMTALA Transfer Policy and **is now reflected in the policy draft. A new** system wide policy was developed to reflect this language and inclusion of current EMTALA and associated State law. The draft of this policy was reviewed by the Medical Executive Committee on December 1, 2014. 12/1/2014 The committee reviewed the policy and requested additional information. The final draft will be approved by the Medical Executive Committee on January 5, 2015. 1/5/2015 (See attachment # 1 - Draft EMTALA Transfer Policy) (See attachment # 7 – Medical Staff Executive Committee Meeting Agenda)	

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A2401	Continued From page 6 obstetrician)...who rec (recommended) indomethacin (Indocin) but med (medication) unavailable here at east. due to early pregnancy pt (patient) will go emergency transport to (Hospital #2) L/D (Labor and Delivery) for OB (Obstetrician) eval (evaluation)." Medical record review of a nurse's note dated April 2, 2014, at 9:27 a.m., revealed, "Disposition: (Hospital #2) Transport: Ambulance, Patient left the department." Medical record review revealed OB did not see the patient in the ED and was not notified of Indocin being unavailable. Further medical record review revealed no documentation regarding a pelvic examination, fetal heart tones being monitored, or obtaining timing of any contractions. Review of an EMS (Emergency Medical Service) Patient Care Report dated April 2, 2014, revealed, "...Level of Care: ALS (Advanced Life Support)...At patient (9:15 a.m.)...Transport: (9:25 a.m.) At dest (destination): (9:43 a.m.)...Narrative: Dispatched emer (emergent) to (Facility) to transfer pt (patient) to (Hospital #2)...pt in premature labor...nurse advised '...they performed an ultrasound and the cervix was not even visible so they called for transfer...have given her 1 liter NS (normal saline), 8 mg (milligrams) Morphine, 0.5 Dilaudid, and 4 mg of Zofran. Pt has had no pain relief.' Further ALS asses (assessment) revealed pt was having contractions at 1-2 min's (minutes) apart, pt was not on a fetal heart rate monitor, and had no Tocolytics (medication to slow contractions) on board...continued to have contractions at 1-2 mins part, right before arrival at (Hospital #2) pt	A2401	**Review of the medical record of patient # 7 will be formally reviewed by the Chief of Emergency Medicine on 12/9/2014. Based on this case new guidelines for management of obstetric patients in the Erlanger East Emergency Department has been developed and approved by the Chief of Emergency Medicine/Erlanger East Medical Director on 12/3/2014. (See attachment #11)**	12/9/2014

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A2401	Continued From page 7 stated she felt like something was coming out. Upon initial evaluation nothing was seen, but then her water broke and both the baby's feet presented toes pointing upward...pt could not push anymore, the feet were purple had no movement. By this time we were at (Hospital #2) and diverted straight to the ER (Emergency Room). Moved pt to bed...staff started to deliver baby. When baby was fully delivered it was lifeless and staff did not attempt resuscitation...pt could not sign due to staff rushing her to L&D..." Medical record review of Hospital #2's ER record dated April 2, 2014, revealed, "Complaint: 21 week ob breech presentation Triage Time...(9:47 a.m.)...Pain: 10 (0-10)...brought in by...ems (emergency medical service), transfer from (facility)...feet of fetus are visible (9:49 a.m.)...Medications prior to arrival, morphine...8 mg (milligrams), dilaudid...0.5 mg...zofran 4 mg." Medical record review of an ultrasound report dated April 2, 2014, at 9:00 a.m. (performed at the facility before transfer), revealed, "...Results: A viable intrauterine pregnancy is identified, estimated gestational age 20 weeks and 2 days. The heart rate...measures 136 beats per minute. Of note the cervical canal is poorly identified, and the cervical os appears to be abnormally dilated up to 4.2 cm (centimeters)...findings compatible with incompetent cervix. GYN (Gynecology) assessment recommended." Medical record review of a Newborn Identification record dated April 2, 2014, revealed, "...Infant's Birth Date April 2, 2014, at (9:50 a.m.) Sex male...Weight 364 gm (grams) Length 26 cms (centimeters)..."	A2401		

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A2401	Continued From page 8 Medical record review of a physician's progress note dated April 2, 2014, at 9:59 a.m., revealed, "...NICU (neo-natal intensive care unit) and OB paged directly on arrival. Pt preterm did not know...was pregnant. Did not go into labor/contractions...Fetus blue/red on arrival. Fetus delivered, non-viable with OB assistance in ED (emergency department). Cord clamped...Pt transported to L+D (labor and delivery) for placental." Medical record review of a history and physical dated April 2, 2014, revealed, "...(10:02 a.m.) Chief Complaint: arrives c/o (complains of) labor. Breech presentation noted...Did not know she was pregnant. 21 weeks by LMP. NO prenatal care...Pain controlled. Fetus non viable. No alleviating or aggrevating (aggravating) factors. Pain cramping to lower abd (abdomen). No sig (significant) bleeding...In my professional medical judgment...this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...reports vaginal bleeding, vaginal discharge...Pelvic: Bimanual exam abnormal, Cervix dilated 2 cm (centimeters), fetus in breech presentation, legs at introitus on arrival..." Medical record review of a physician's progress note dated April 2, 2014, at 10:57 a.m., revealed, "Precipitous Delivery...OB notified of patients arrival to the emergency department. Infant delivered via vaginal delivery, at (9:50 a.m.)...Initial APGAR score...3 (0-10, higher score	A2401		

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A2401	Continued From page 9 indicative of better clinical condition) Patient tolerated the procedure with difficulty..." Medical record review of a physician's progress note dated April 2, 2014, at 11:00 a.m., revealed, "...OB Called to ER for delivery of preterm with no prenatal care...had presented to (facility) with abd pain and cramps...transferred to ER here where she delivered non-viable male infant...Placenta remains intact..." Medical record review of a Bereavement Loss Checklist L&D dated April 2, 2014, revealed, "...Complications this pregnancy: Preterm labor Obstetrician: (M.D. #2) Delivery Date/Time: 4-2-14 at (9:50 a.m.) Death date/Time: 4-2-14 at (9:50 a.m.)...Sex: M (male)..." Medical record review revealed, "...04/02/2014 (9:26 p.m.)...Delivery Time: Placenta - Manual." Medical record review revealed the patient was discharged on April 2, 2014. Interview with the Corporate Preparedness/Safety Officer on May 9, 2014, at 2:40 p.m., in a conference room, revealed the facility did not have current approved EMTALA policies for Hospital #1 except for a transfer policy. Further interview confirmed the unapproved policy with an origination date of March 2014 was under review. Interview with the ER Nurse Manager on May 12, 2014, at 10:20 a.m., in a conference room, revealed the facility had provided labor and delivery services since 1996, delivered infants of 35-36 weeks gestation through full term, had the capability of providing monitoring of fetal heart tones in the ED, and had OB on call. She stated,	A2401		

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A2401	Continued From page 10 "...unless high risk, and under EMTALA we just deliver, pray for the best, and after delivery transport downtown (Hospital #2)." Interview with the ED's Medical Director on May 12, 2014, at 11:58 a.m., in a conference room, and in the presence of the facility's Corporate Preparedness/Safety Officer, revealed Patient #7 presented to Hospital #2 and he delivered Patient #7's infant. Continued interview confirmed the facility's East campus inappropriately transferred Patient #7 on April 2, 2014, and confirmed Patient #7 was transferred to Hospital #2 in an unstable medical condition. He stated, "...When patient arrived, I didn't have time to read her paperwork. The feet were already out and we had to deliver."	A2401		
A2402	489.20(q) POSTING OF SIGNS [The provider agrees,] in the case of a hospital as defined in §489.24(b), to post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX.	A2402	A2402: 489.24(q) POSTING OF SIGNS **The findings included:** This STANDARD is not met as evidenced the facility failed to conspicuously post the required signs with respect to the right to examination and treatment for emergency medical conditions and women in labor. **Plan of Correction Responsibility:** The Medical Director for Emergency Services has the responsibility for the plan of correction.	

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A2402	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to conspicuously post the required signs with respect to the right to examination and treatment for emergency medical conditions and women in labor. The findings included: Observation of the facility's Emergency Room (ER) with a Nurse Manager on May 9, 2014, at 10:20 a.m., revealed the required signs were not posted in the patient/family waiting area of the ER. (Required signs inform patients of the right to receive an appropriate medical screening examination, necessary stabilizing treatment, and if necessary an appropriate transfer if the patient has a medical emergency, regardless of ability to pay, and if the facility does/does not participate in the Medicaid program.) Interview with a Nurse Manager on May 9, 2014, at approximately 10:30 a.m., in the outpatient surgery entrance, confirmed the facility failed to conspicuously post the required signs.	A2402	**When/How Corrected:** The signage was partially blocked at the Erlanger East Emergency Room entrance by the vending machines and no signage was posted at the desk inside the Emergency Department registration/information counter. 1. The vending machines were moved in order to have total view of the required signage at the Erlanger East Emergency Department entrance. Corrected during survey 5/12/2014 2. The required signage was posted behind the Erlanger East Emergency Department registration/information counter in the waiting room. Corrected during Survey 5/21/2014 3. The required signage was posted at the Erlanger East Ambulatory Entrance (Attachments #8 – photos of posted required signage)	5/12/2014 5/12/2014 11/24/2014
A2409	489.24(e)(1)-(2) APPROPRIATE TRANSFER (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's	A2409		

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A2409	Continued From page 12 obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based. (2) A transfer to another medical facility will be appropriate only in those cases in which - (i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;	A2409		

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A2409	Continued From page 13 (ii) The receiving facility (A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment. (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and (iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer. This STANDARD is not met as evidenced by: Based on review of facility policy, review of Rules and Regulations of the Medical Staff, review of Emergency Room Logs, medical record review, and interview, the facility failed to appropriately	A2409	A2409: 489.24(e)(1)-(2) Appropriate Transfers **The findings included:** This STANDARD is not met as evidenced by: Based on review of facility policy, review of Rules and Regulations of the Medical Staff, review of Emergency Room Logs, medical record review, and interview, the facility failed to appropriately transfer four patients (#7, #8, #9, and #11) of the 16 patients reviewed. **Plan of Correction Responsibility:** The Chief Medical Officer and the Chief of Emergency Medicine is responsible for the corrective action plan and ongoing compliance.	

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A2409	Continued From page 14 transfer four patients (#7, #8, #9, and #11) of sixteen patients reviewed. The findings included: Review of facility policy titled "Transfers...PC.074" most recently revised in February, 2012, revealed, "...To establish guidelines for transferring patient within a facility, to an alternative level of care, or to another acute care facility while assuring medically appropriate continuity of care and compliance with EMTALA (Emergency Medical Treatment and Active Labor Act) regulation...The following information must be completed prior to a transfer...transferring physician must obtain acceptance from a receiving physician...receiving facility must accept the patient...patient and/or family members consent...Copies of the completed Emergency Department (ED) record, lab results/x-rays and EKG reports will be sent with patient...Transfer form completed. The transferring physician determines the method of patient transport and the amount of support that will be needed during transport. The transferring physician also maintains responsibility for care during transport until arrival at the receiving facility..." Review of a policy titled "(Facility) East Emergency Services Scope of Services" revealed, "Origination Date: 3/14" and the approval date was blank, indicating it had not been approved by the Medical Staff or the Governing Body. Review of facility policy for the hospital's main campus titled "Emergency Department Scope of Services Number: EMS.280" most recently revised in March, 2010, revealed, "...An	A2409	**When/How Corrected:** Hospital # 1 is within the Erlanger Health System; however this was not reflected in the EMTALA Transfer Policy and **is now reflected in the policy draft. A new** system wide policy was developed to reflect this language and inclusion of current EMTALA and associated State law. The draft of this policy was reviewed by the Medical Executive Committee on December 1, 2014. The committee reviewed the policy and requested additional information. The final draft will be approved by the Medical Executive Committee on January 5, 2015. (See attachment # 1 - Draft EMTALA Transfer Policy) (See attachment # 7 – Medical Staff Executive Committee Meeting Agenda) **The Emergency Services Scope of Services policies (EMS #280 and EEED #7174.100) were reviewed and approved to include documentation of approval by the Chief of Emergency Medicine, and revision of the staffing model for Erlanger Baroness Campus. These policies are departmental policies that are required by all departments explaining the scope of the services the department provides, staffing for the department, special equipment and procedures.** **(See attachment #2 and #10.)**	12/1/2014 12/5/2014 11/24/2014

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A2409	Continued From page 15 Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of prompt and appropriate medical attention could result in...placing the health or safety of the patient or unborn child in serious jeopardy...The following conditions are declared to be emergency conditions by statute and regulation ...pregnancy with contractions present...acute pain rising to the level of the general definition of emergency medical condition...Evaluation, management, and treatment of patients is appropriate and expedient...Immediate evaluation and stabilization, to the degree reasonably possible, will be available for each patient who presents with an emergency medical condition...Necessary equipment...supplies must be immediately available in the facility at all times...Necessary drugs and agents must be immediately available in the facility at all times...Patients are to be transported to the nearest appropriate ED (emergency department) in accordance with applicable laws, regulations, and guidelines...All transfers will comply with local, state, and federal laws...Equipment and Supplies...Radiological, Imaging and Diagnostic Services Available 24/7 (24 hours per day/7 days per week)...fetal monitoring..." Review of Rules and Regulations of the Medical Staff revealed, "...Effective date: December 7, 1995...A phone call from the requesting physician to the consultant is required for emergent/urgent consults to ensure clear communication regarding the clinical situation and timely coordination of care...The need for consultation will be determined by the (ED) physician...A satisfactory consultation includes examination of	A2409		

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A2409	Continued From page 16 the patient and the record. A written or dictated opinion signed by the consultant must be included in the medical record. For emergent/urgent situations, the consulting physician should discuss findings directly with the referring physician in addition to the written documentation...Medical records contain...Emergency care, treatment, and services provided to the patient before his or her arrival, if any...Documentation and findings of assessments...Conclusion or impressions drawn from medical history and physical examination...Progress notes made by authorized individuals...Consultation reports...All medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided..." Review of an Emergency Room Log dated April 2, 2014, revealed Patient #7 presented to the facility's East campus with complaint of Vaginal Bleeding. Medical record review of a Triage note dated April 2, 2014, revealed, "...(6:37 a.m.) Complaint: Vaginal bleeding...(6:49 a.m.) Pain level 9 (0-10)...Quality is cramping. Since yesterday...states...is a 'couple weeks pregnant'...had a miscarriage in Jan (January) LMP (Last Menstrual Period): 11-15-2013 (history of five pregnancies, three delivered pregnancies)..." Medical record review of a history and physical dated April 2, 2014, at 7:14 a.m., revealed, "pt (patient) w/ (with) abd (abdominal) pain. lmp (last mentrual period) 11/5/13. thought she had miscarriage in January due to heavy bleeding and	A2409		

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A2409	Continued From page 17 passing tissue. Was told last week that she is pregnant again. now having severe cramps. had some light bleeding past 2 days. today no bleeding but severe cramps. vomit x (times) 2. no diarrhea. no urinary sx (symptoms). no fever...Sudden onset of symptoms, Symptoms are worsening, are constant. Maximum severity of symptoms severe, Currently symptoms are severe. In my professional medical judgment...this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that in the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ...(7:18 a.m.) Abdominal exam included findings of abdomen tender, to the left upper quadrant, to the left lower quadrant, to the right lower quadrant, moderate intensity, no distension, firm uterus at umbilicus...Medical History...miscarriage x 2...cesarean section..." Medical record review of a physician's progress note dated April 2, 2014, at 7:20 a.m., revealed, "...BSUS (Bedside Ultrasound) shows IUP (Intrauterine Pregnancy) at approx 20 wks (approximately 20 weeks). Will obtain formal us (ultrasound), labs, and ob (obstetric) consult..." Medical record review of the Nursing Assessment: Continuing Assessment dated April 2, 2014, revealed, "...(7:24 a.m.) per pt she miscarried in January at home and was never seen by OBGYN (Obstetrician/Gynecologist) to confirm. Pt sts (states) she was seen by OBGYN recently, but could not give specific day or date, and was told her blood pregnancy test was	A2409		

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A2409	Continued From page 18 positive. Pt sts she is 'a couple of weeks pregnant'...patient appears, restless, uncomfortable...(7:40 a.m.) pt rates pain 8 on a scale of 1-10. MD notified new medication order received...(8:12 a.m.) States worsening pain, pt still c/o pain an 8 on a scale of 1-10. MD notified and new medication order received...Patient appears restless, uncomfortable...(8:56 a.m.) States decreased pain, Patient states decreased pain, although she still rates it 7 out of 10. She is not as restless and seems in no pain distress at this time. pain is more intermittent at this time... (9:10 a.m.) States worsening pain...Patient appears, uncomfortable..." Medical record review of a physician's note dated April 2, 2014, at 8:53 a.m., revealed, "Diagnosis Final: Primary Preterm Labor." Medical record review of a nurse's note dated April 2, 2014, at 8:54 a.m., revealed, "Ambulance service contacted...Estimated time of arrival 15-20 min (minutes)." Medical record review of a nurse's note dated April 2, 2014, at 9:06 a.m., revealed, "Indocin (medication to delay labor) ordered by (Medical Doctor - M.D. #1). Pharmacy called and we do not carry that medication on this campus. MD (MD #1) aware, medication order canceled." Medical record review of a nurse's note dated April 2, 2014, at 9:14 a.m., revealed, "Transfer: Reason for transfer need for specialized care, Diagnosis: preterm labor, Accepting Institution: (Hospital #2) Labor and Delivery, Accepting physician (M.D. #2)...Report called to receiving facility..."	A2409	**Indocin is now stocked at the Erlanger East campus pharmacy and available – Indomethacin dosage = 25mg x2 (50mg) PO stat then 25mg PO every 6 hours. Magnesium and Terbutaline are also available if requested.**	12/5/2014

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A2409	Continued From page 19 Medical record review of a Transfer Authorization dated April 2, 2014, at 9:18 a.m., revealed, "STABILITY The patient is stabilized at the time of transfer and no medical deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from this facility, or, with respect to a pregnant woman having contractions, the woman has delivered (including the placenta) OR The Patient is in a state of an emergency medical condition, and I hereby certify that based upon the information available to me at this time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility, outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer..." Review of the Transfer Authorization revealed both statements were checked. Further review revealed, "...appropriate transport service...Advanced...The receiving facility has agreed to accept the patient...Facility (Hospital #2)...accepting physician (M.D. #2)..." Continued review revealed, "...Reason for transfer: preterm labor Risk of transfer: death by MVC (motor vehicle crash) Benefits of transfer: higher level of care..." Medical record review of a physician's progress note dated April 2, 2014, at 9:22 a.m., revealed, "formal us (ultrasound) shows (20 week intrauterine pregnancy) and incompetent cervix. Discussed results (with M.D. #2 - patient's obstetrician)...who rec (recommended) indomethacin (Indocin) but med (medication) unavailable here at east. due to early pregnancy pt (patient) will go emergency transport to (Hospital #2) L/D (Labor and Delivery) for OB (Obstetrician) eval (evaluation)."	A2409	Transfer Authorization form revealed it had been completed inappropriately. It revealed both statements were checked (stable or state of emergency medical condition). A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. **Education:** **Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.**	11/24/2014 12/5/2014 12/31/2014

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A2409	Continued From page 20 Medical record review of a nurse's note dated April 2, 2014, at 9:27 a.m., revealed, "Disposition: (Hospital #2) Transport: Ambulance, Patient left the department." Medical record review revealed OB did not see the patient in the ED and was not notified of Indocin being unavailable. Further medical record review revealed no documentation regarding a pelvic examination, fetal heart tones being monitored, or obtaining timing of any contractions. Review of an EMS (Emergency Medical Service) Patient Care Report dated April 2, 2014, revealed, "...Level of Care: ALS (Advanced Life Support)...At patient (9:15 a.m.)...Transport: (9:25 a.m.) At dest (destination): (9:43 a.m.)...Narrative: Dispatched emer (emergent) to (Facility) to transfer pt (patient) to (Hospital #2)...pt in premature labor...nurse advised '...they performed an ultrasound and the cervix was not even visible so they called for transfer...have given her 1 liter NS (normal saline), 8 mg (milligrams) Morphine, 0.5 Dilaudid, and 4 mg of Zofran. Pt has had no pain relief.' Further ALS asses (assessment) revealed pt was having contractions at 1-2 min's (minutes) apart, pt was not on a fetal heart rate monitor, and had no Tocolytics (medication to slow contractions) on board...continued to have contractions at 1-2 mins part, right before arrival at (Hospital #2) pt stated she felt like something was coming out. Upon initial evaluation nothing was seen, but then her water broke and both the baby's feet presented toes pointing upward...pt could not push anymore, the feet were purple had no movement. By this time we were at (Hospital #2)	A2409	**Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 by the Emergency Department Nurse Manager at Erlanger East. A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved. Results will be reported to the Erlanger Health System Quality Oversight Committee. **Review of the medical record of patient # 7 will be formally reviewed by the Chief of Emergency Medicine on 12/9/2014. Based on this case new guidelines for management of obstetric patients in the Erlanger East Emergency Department has been developed and approved by the Chief of Emergency Medicine/Erlanger East Medical Director on 12/3/2014. (See attachment #11)**	1/2015-4/1015 12/9/2014 12/3/2014

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A2409	Continued From page 21 and diverted straight to the ER (Emergency Room). Moved pt to bed...staff started to deliver baby. When baby was fully delivered it was lifeless and staff did not attempt resuscitation...pt could not sign due to staff rushing her to L&D..." Medical record review of Hospital #2's ER record dated April 2, 2014, revealed, "Complaint: 21 week ob breech presentation Triage Time...(9:47 a.m.)...Pain: 10 (0-10)...brought in by...ems (emergency medical service), transfer from (facility)...feet of fetus are visible (9:49 a.m.)...Medications prior to arrival, morphine...8 mg (milligrams), dilaudid...0.5 mg...zofran 4 mg." Medical record review of an ultrasound report dated April 2, 2014, at 9:00 a.m. (performed at the facility before transfer), revealed, "...Results: A viable intrauterine pregnancy is identified, estimated gestational age 20 weeks and 2 days. The heart rate...measures 136 beats per minute. Of note the cervical canal is poorly identified, and the cervical os appears to be abnormally dilated up to 4.2 cm (centimeters)...findings compatible with incompetent cervix. GYN (Gynecology) assessment recommended." Medical record review of a Newborn Identification record dated April 2, 2014, revealed, "...Infant's Birth Date April 2, 2014, at (9:50 a.m.) Sex male...Weight 364 gm (grams) Length 26 cms (centimeters)..." Medical record review of a physician's progress note dated April 2, 2014, at 9:59 a.m., revealed, "...NICU (neo-natal intensive care unit) and OB paged directly on arrival. Pt preterm did not know...was pregnant. Did not go into labor/contractions...Fetus blue/red on arrival.	A2409		

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A2409	Continued From page 22 Fetus delivered, non-viable with OB assistance in ED (emergency department). Cord clamped...Pt transported to L+D (labor and delivery) for placental." Medical record review of a history and physical dated April 2, 2014, revealed, "...(10:02 a.m.) Chief Complaint: arrives c/o (complains of) labor. Breech presentation noted...Did not know she was pregnant. 21 weeks by LMP. NO prenatal care...Pain controlled. Fetus non viable. No alleviating or aggrevating (aggravating) factors. Pain cramping to lower abd (abdomen). No sig (significant) bleeding...In my professional medical judgment...this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...reports vaginal bleeding, vaginal discharge...Pelvic: Bimanual exam abnormal, Cervix dilated 2 cm (centimeters), fetus in breech presentation, legs at introitus on arrival..." Medical record review of a physician's progress note dated April 2, 2014, at 10:57 a.m., revealed, "Precipitous Delivery...OB notified of patients arrival to the emergency department. Infant delivered via vaginal delivery, at (9:50 a.m.)...Initial APGAR score...3 (0-10, higher score indicative of better clinical condition) Patient tolerated the procedure with difficulty..." Medical record review of a physician's progress note dated April 2, 2014, at 11:00 a.m., revealed, "...OB Called to ER for delivery of preterm with no	A2409		

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A2409	Continued From page 23 prenatal care...had presented to (facility) with abd pain and cramps...transferred to ER here where she delivered non-viable male infant...Placenta remains intact..." Medical record review of a Bereavement Loss Checklist L&D dated April 2, 2014, revealed, "...Complications this pregnancy: Preterm labor Obstetrician: (M.D. #2) Delivery Date/Time: 4-2-14 at (9:50 a.m.) Death date/Time: 4-2-14 at (9:50 a.m.)...Sex: M (male)..." Medical record review revealed, "...04/02/2014 (9:26 p.m.)...Delivery Time: Placenta - Manual." Medical record review revealed the patient was discharged on April 2, 2014. Interview with the ER Nurse Manager on May 12, 2014, at 10:20 a.m., in a conference room, revealed the facility had provided labor and delivery services since 1996, delivered infants of 35-36 weeks gestation through full term, had the capability of providing monitoring of fetal heart tones in the ED, and had OB on call. She stated, "...unless high risk, and under EMTALA we just deliver, pray for the best, and after delivery transport downtown (Hospital #2)." Interview with a Registered Pharmacist on May 12, 2014, at 11:23 a.m., in a conference room, revealed the pharmacy did not stock Indomethacin, but the medication used to delay labor could be stocked on the recommendation of physicians. Interview with the ER's Medical Director on May 12, 2014, at 11:58 a.m., in a conference room, and in the presence of the facility's Corporate	A2409		

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A2409	Continued From page 24 Preparedness/Safety Officer, revealed Patient #7 presented to Hospital #2 and he delivered Patient #7's infant. Continued interview confirmed the facility inappropriately transferred Patient #7 on April 2, 2014, and he stated, "...When patient arrived, I didn't have time to read her paperwork. The feet were already out and we had to deliver." Review of an ER Log revealed Patient #8 presented to the ER on April 18, 2014. Medical record review of an ER Record dated April 18, 2014, revealed Patient #8 presented to the ER with a complaint of abdominal pain. Medical record review of a Nursing Assessment dated April 18, 2014, at 8:58 a.m., revealed, "...pressure pain, to the right lower quadrant...on a scale 0-10 patient rates pain as 10..." Medical record review of a history and physical dated April 18, 2014, at 9:01 a.m., revealed, "...abdominal pain that started 3 days ago. Pain is sharp, constant, started in right upper but now pain to RLQ (Right Lower Quadrant) as well. No radiation to back...are constant...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...(9:03 a.m.) tachycardic...tenderness to right side of abdomen...with voluntary guarding..." Medical record review of a physician's note dated	A2409	A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. (See attachment #4) **Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East.** A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved, Results will be reported to the Erlanger Health System Quality Oversight Committee.	11/24/2014 12/5/2014 1/2015-4/1015

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A2409	Continued From page 25 April 18, 2014, at 9:04 a.m., revealed, "abdominal pain with signficant tenderness and guarding, will check labs, treat pain, do ultrasound." Medical record review of a Medication Administration Summary dated April 18, 2014, revealed the patient was administered pain medication at 9:18 a.m. and 10:32 a.m., and an antiblotic at 9:44 a.m, according to physician's orders. Medical record review of a Nursing Procedure: Communications dated April 18, 2014, at 9:24 a.m., revealed, "...WBC (White Blood Cell) count 32.7 (normal range 4.8-10.8), given to (MD #4)..." Medical record review of a physician's note dated April 18, 2014, at 9:47 a.m., revealed, "ultrasound positive for acute cholecystitis, will send to Main ER (Hospital #2) for surgical evaluation, will give abx (antibiotics) given patient on immunosuppressive meds with WBC 32." Medical record review of a radiology report dated April 18, 2014, at 10:08 a.m., revealed, "...large 2 cm stone in the neck of the gallbladder...gallbladder enlarged to 13 cm...in length...Impression...very suggestive of cholecystitis." Medical record review of the Emergency Department Emergency Record documentation dated April 18, 2014, at 9:50 a.m., revealed, "...Transfer to...(Hospital #2) ED..." Medical record review of a nurse's note dated April 18, 2014, at 9:58 a.m., revealed, "...Reason for transfer need for specialized care, Diagnosis: cholecystitis, Accepting institution: (Hospital #2),	A2409	Education: Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.	12/31/2014

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A2409	Continued From page 26 Accepting physician: (MD #6)...Transported by non-urgent ambulance...consent for transfer signed..." Medical record review of the Transfer Authorization dated April 18, 2014, revealed, "Stability The patient is stablized at the time of transfer and no medical deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from this facility...OR The Patient is in a state of an emergency medical condition, and I hereby certify that based upon the information available to me at this time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility, outweigh the increased risks to the individual...OR Patient/Responsible Individual requests transfer..." Review of the Transfer Authorization revealed all three options were checked. Further review of the Transfer Authorization revealed, "...It is medically necessary to transport the patient by ambulance/air ambulance..." was not checked. Further review revealed no Confirmation Time for Hospital #2's acceptance of the patient; no time was documented when report was given to the accepting hospital staff; and no time was documented for when the patient was transferred. Medical record review of an ER Record (Hospital #2) history and physical dated April 18, 2014, at 11:45 a.m., revealed, "...Transfer from outer facility for higher level of care...Symptoms are worsening, are constant...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate	A2409	A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. (See attachment #4) **Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East.** A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved. Results will be reported to the Erlanger Health System Quality Oversight Committee.	12/5/2014 1/2015-4/1015

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A2409	Continued From page 27 medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part..." Medical record review of the Hospital #2 Emergency Department Emergency Record dated April 18, 2014, revealed the patient was transported to surgery at 1:58 p.m. Medical record review of a Discharge Summary dated April 20, 2014, revealed, "..taken to operating room for a laparoscopic cholecystectomy with intraoperative cholangiogram...on postop day 2, the day of discharge, will be discharged home..." Interview with the Corporate Preparedness/Safety Officer on May 12, 2014, at 3:35 p.m., in a conference room, confirmed Patient #8 was inappropriately transferred on April 18, 2014. Review of an ER Log revealed Patient #9 presented to the ER on April 18, 2014. Medical record review of an ER Record dated April 18, 2014, revealed, "...(3:15 p.m.) Trauma tuesday...Complaint: bilateral leg tenderness, swelling...(3:25 p.m.) Triage Information...Pain level 8 (0-10)...noticed some increased swelling...concerned about compartment syndrome...Pt has swelling and pain in left calf..." Medical record review of a history and physical dated April 18, 2014, at 4:39 p.m., revealed, "...recently admitted and released from hospital last night from traumatic injury while at work. Had skull fracture, left tibia fracture and right ankle	A2409	**Education:** **Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.**	12/31/2014

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A2409	Continued From page 28 fracture...had PT (Physical Therapy) come out today, but was told to come directly to ER for increased swelling and pain to left calf. Worried about DVT (Deep Vein Thrombosis) poss (possible) compartment syndrome...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...large amount of swelling to left calf with tenderness..." Medical record review of a Nurse Practitioner's note dated April 18, 2014, at 4:46 p.m., revealed, "with calf swelling, with recent trauma with ankle fracture, will US (ultrasound) r/o (rule out) DVT...with US, DVT noted with fluid, concerning for compartment syndrome. (M.D. #4) spoke with (MD #11) with trauma, patient will be sent to (Hospital #2) ER downtown for further evaluation." Medical record review of a nurse's note dated April 18, 2014, at 5:09 p.m., revealed, "...Reason for transfer, pt being transferred to the ED, Diagnosis: DVT, Transported by non-urgent ambulance, Copy of patient record prepared for receiving facility, Medication reconciliation form prepared and sent to receiving facility, Patient consent for transfer signed, Family member contacted." Medical record review of the ED record revealed medications administered to the patient in the ED were Dilaudid and Phenergan for pain and	A2409		

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A2409	Continued From page 29 nausea. Medical record review revealed no transfer form, Transfer Authorization, or consent for transfer was found in the medical record. Medical record review of Hospital #2's ER Record revealed, "(5:55 p.m.)...Complaint: DVT LLE (Left Lower Extremity)...Patient transferred from another facility..." Medical record review of the ED physician history and physical dated April 18, 2014, at 7:07 p.m., revealed, "...bilateral leg and facial trauma, discharged from (Hospital #2) and then developed severe bilateral leg pain, worse on the left...There has been no change in the patient's symptoms over time, are constant...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...(8:47 p.m.) Pulse, tachycardic...extremities swollen bilaterally..." Medical record review of the nursing notes revealed the patient was started on heparin (anticoagulant commonly administered for DVT) on April 18, 2014, at 7:10 p.m. Medical record review of an Admission Request dated April 18, 2014, at 8:45 p.m., revealed, "Condition: Fair...Hospital Service: Surgery - Trauma..."	A2409	**Corrective Action Plan:** Health Information Management (HIM) did not have a scanned copy of the Transfer Form for pt #9. **It is unclear why the transfer form was not in the permanent electronic medical record.** **The Erlanger East Emergency department now scans a copy of the completed/signed transfer form into the electronic emergency room record to assure the document is retained in the record.** **Monitoring of the Corrective Action Process:** Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East.** A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form and presence in the medical record with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved, Results will be reported to the Erlanger Health System Quality Oversight Committee.	June 2014 1/2015-4/1015

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A2409	Continued From page 30 Medical record review of a nurse's note dated April 18, 2014, at 10:18 p.m., revealed, "Admission: Patient admitted to telemetry unit...STAT (immediate) admission orders completed..." Medical record review of the ER Nursing Notes revealed the patient was admitted to inpatient on April 19, 2014, at 12:39 a.m. Telephone interview with the Corporate Preparedness/Safety Officer on May 13, 2014, at 1:30 p.m., revealed the facility was unable to locate a transfer form, Transfer Authorization, or consent form for transfer and confirmed Patient #9 was inappropriately transferred on April 18, 2014. Review of an ER Log revealed Patient #11 presented to the ER on March 31, 2014. Medical record review of an ER Record dated March 31, 2014, revealed, "(12:35 p.m.) Complaint: Hip Pain, right hip." Medical record review of a nurse's note dated March 31, 2014, at 12:44 p.m., revealed, "Triage Information: seen her (here) on 3/26 for rigt (right) hip and leg pain. pt continues to have this pain and is not able to sleep well. Pt has been taking tylenol and motrin that is not helping pain." Medical record review of a history and physical dated March 31, 2014, at 12:44 p.m., revealed, "...Cerebral Palsy, seizure disorder, cerebral atonia, severe thoracolumbar scoliosis, osteoporosis...(12:58 p.m.) patient was seen last Wednesday for bruising to right leg. Unsure of	A2409	The HIM department uses the scanning process for all records scanned and verification that all documents received are scanned. In addition HIM retains the hard copy of the record for 60 days before they are destroyed - ongoing process.	Ongoing

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ERLANGER MEDICAL CENTER	975 E 3RD ST CHATTANOOGA, TN 37403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A2409	Continued From page 31 any injury or trauma. Patient is non weight bearing. wheel chair bound only. Uses assistance when transferring from wheelchair to recliner...patient has CP (Cerebral Palsy), is non-verbal...Gradual onset of symptoms, 7, days prior to arrival. There has been no change in the patient's symptoms over time, are constant...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...(1:01 p.m.) Patient appears, in mild pain distress, Patient appears to be uncomfortable...Lower extremity exam included finidngs of inspection abnormal no abrasions, contusions present, no deformity...right medial upper thigh, Range of motion, limited to the right hip..." Medical record review of a Family Nurse Practitioner's note dated March 31, 2014, at 1:02 p.m., revealed, "...brought back in for persistent pain. X-ray over-read shows femoral neck fracture. Will CT and call ortho (orthopedics). Caretaker is unsure of any injury or trauma patient has had in the past week...Spoke with (M.D. #6), will look at CT and speak with ortho attending. Patient will need to be sent to ER to be evaluated by ortho." Medical record review of a radiology report (CT) dated March 31, 2014, at 1:13 p.m., revealed, "Comparison: Right femur fracture, 3/26/2014...Impression: An acute, comminuted fracture of right femoral neck with markedly	A2409		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440104	A. BUILDING _____ B. WING _____	C 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERLANGER MEDICAL CENTER	975 E 3RD ST CHATTANOOGA, TN 37403

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A2409	Continued From page 32 displaced fracture fragments as discussed..." Medical record review of a nurse's note dated March 31, 2014, at 3:30 p.m., revealed, "...Reason for transfer need for specialized care, Diagnosis: Femur Fracture, accepting institution (Hospital #2), Accepting physician (M.D. #7), Referring physician: (M.D. #1/FNP), Transported by non-urgent ambulance..." Medical record review of a Transfer Authorization dated March 31, 2014, revealed, "Stability The patient is stablized at the time of transfer and no medical deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from this facility...OR The Patient is in a state of an emergency medical condition, and I hereby certify that based upon the information available to me at this time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility, outweigh the increased risks to the individual...OR Patient/Responsible Individual requests transfer..." Review of the Transfer Authorization revealed all three options were checked. Further review of the Transfer Authorization revealed it was not documented who the aceepting physician was or who the transferring facility was. Medical record review of the ER record dated March 31, 2014, at 3:37 p.m., revealed, "...Disposition Transport: Ambulance, Patient left the department..." Medical record review of a Orthopedic Consultation Report (Hospital #2) dated March 31, 2014, revealed, "...signs of painful hip since	A2409	A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. (See attachment #4) **Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East**. A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form and presence in the medical record with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved, Results will be reported to the Erlanger Health System Quality Oversight Committee.	12/5/2014 1/2015-4/1015

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A2409	Continued From page 33 last Wednesday (March 26, 2014)...At that time, x-rays were taken, which in retrospect showed a femoral neck fracture that was missed, and the patient was sent (home)...would then show signs of significant pain any time his leg was moved or anytime he was transferred from bed to chair...x-ray of the right hip shows a displaced, shortened and varus femoral neck fracture. CT confirms this fracture and also shows comminution, as well as what appears to be a Pauwels III orientation of the femoral neck fracture...Patient will likely go to the operating room tomorrow..." Interview with the Corporate Preparedness/Safety Officer on May 12, 2014, at 8:00 p.m., in a conference room, confirmed Patient #11 was inappropriately transferred. Interview with the Corporate Preparedness/Safety Officer on May 9, 2014, at 2:40 p.m., in a conference room, revealed the facility did not have current approved EMTALA policies for Hospital #1 (facility or the East Campus) except for a transfer policy. Further interview confirmed the unapproved policy with an origination date of March 2014 was under review. Interview with the ED Medical Director on May 12, 2014, at 11:58 a.m., in a conference room and the presence of the Corporate Preparedness/Safety Officer, revealed EMTALA policy "verbage is in our bylaws."	A2409	**Education:** **Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.**	12/31/2014

For immediate release
February 6, 2015

NEWS NEWS NEWS NEWS

Erlanger announces collaboration with Columbia HeartSource

Chattanooga, Tenn. – Erlanger Health System announced today that it will collaborate with the Columbia University Medical Center's innovative HeartSource program to elevate the scope and quality of heart care in the southeast and beyond.

Charles Campbell, MD, Chief of the UT Erlanger Division of Cardiovascular Medicine, announced the collaboration today at Erlanger, along with Michael Argenziano, MD, Chief of the Adult Cardiac Surgery Section, New York-Presbyterian Hospital/Columbia University Medical Center in New York City.

The Erlanger and Columbia relationship will provide ongoing interaction between cardiologists in New York City and Chattanooga. By sharing clinical data, the two cardiovascular teams can make better decisions, improve patient outcomes and continually increase overall cardiovascular performance. The collaboration allows Erlanger to have 24/7 access to the newest knowledge and therapies in cardiovascular treatment and care.

"When it comes to advancing patient care, collaboration and cooperation are proven to yield greater results," explains Kevin M. Spiegel, FACHE, President & CEO of the Erlanger Health System. "It's all about better outcomes for patients."

Dr. Campbell also recognizes the importance of collaboration. He anticipates drawing on outcomes data from Columbia as his team launches a new heart valve center and heart failure clinic this year. "These are critically important expansions of services for the Chattanooga region," says Dr. Campbell. "Through our affiliation with Columbia HeartSource, we expect even better outcomes."

Columbia ranks among the top 10 cardiology programs in the country, and *US News & World Report* ranks Columbia among the nation's top three "Best Hospitals for Adult Cardiology & Heart Surgery."

US News & World Report also ranks Erlanger as the #1 hospital in Chattanooga. The Erlanger Health System has five Tennessee-based medical campuses, including the region's only children's hospital and Level 1 Trauma Center, providing the highest level of trauma care. Affiliated with the University of Tennessee College of Medicine Chattanooga, Erlanger is the nation's tenth largest public health system. It is also the region's only academic teaching center and treats more than a quarter million patients every year.

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The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

A Correction Has Been Published

Outcomes of PCI at Hospitals with or without On-Site Cardiac Surgery

Thomas Aversano, M.D., Cynthia C. Lemmon, R.N., B.S.N., M.S., and Li Liu, M.D. for the Atlantic CPORT Investigators

N Engl J Med 2012; 366:1792-1802 | May 10, 2012 | DOI: 10.1056/NEJMoa1114540

Abstract

Performance of percutaneous coronary intervention (PCI) is usually restricted to hospitals with cardiac surgery on site. We conducted a noninferiority trial to compare the outcomes of PCI performed at hospitals without and those with on-site cardiac surgery.

We randomly assigned participants to undergo PCI at a hospital with or without on-site cardiac surgery. Patients requiring primary PCI were excluded. The trial had two primary end points: 6-week mortality and 9-month incidence of major adverse cardiac events (the composite of death, Q-wave myocardial infarction, or target-vessel revascularization). Noninferiority margins for the risk difference were 0.4 percentage points for mortality at 6 weeks and 1.8 percentage points for major adverse cardiac events at 9 months.

A total of 18,867 patients were randomly assigned in a 3:1 ratio to undergo PCI at a hospital without on-site cardiac surgery (14,149 patients) or with on-site cardiac surgery (4718 patients). The 6-week mortality rate was 0.9% at hospitals without on-site surgery versus 1.0% at those with on-site surgery (difference, −0.04 percentage points; 95% confidence interval [CI], −0.31 to 0.23; P=0.004 for noninferiority). The 9-month rates of major adverse cardiac events were 12.1% and 11.2% at hospitals without and those with on-site surgery, respectively (difference, 0.92 percentage points; 95% CI, 0.04 to 1.80; P=0.05 for noninferiority). The rate of target-vessel revascularization was higher in hospitals without on-site surgery (6.5% vs. 5.4%, P=0.01).

We found that PCI performed at hospitals without on-site cardiac surgery was noninferior to PCI performed at hospitals with on-site cardiac surgery with respect to mortality at 6 weeks and major adverse cardiac events at 9 months. (Funded by the Cardiovascular Patient Outcomes Research Team [C-PORT] participating sites; ClinicalTrials.gov number, NCT00549796.)

Article

The potential need for emergency cardiac surgery to treat complications related to percutaneous coronary intervention (PCI) suggests that performance of PCI may be best limited to hospitals with on-site cardiac surgery. Among Grüntzig's first 50 PCI procedures, 10% of patients required emergency coronary-artery bypass grafting (CABG).[1] Although the need for emergency surgery subsequently diminished dramatically (by 2002, the incidence was 0.15%[2]), concern about the safety and quality of PCI performed without the availability of on-site cardiac surgery has persisted. Hospitals in which PCI is performed but that do not have cardiac surgery programs could have more adverse events and poorer outcomes for a number of reasons (including low institutional volume of PCI procedures and inexperienced staff), in addition to the need for emergency CABG.

Despite these concerns, many hospitals without on-site cardiac surgery developed stand-alone programs for the performance of primary PCI after studies showed that primary PCI was associated with better outcomes than medical therapy in the treatment of myocardial infarction with ST-segment elevation[3] and could be performed safely and effectively at such hospitals.[4] Door-to-balloon times may be shorter, and outcomes consequently better, if primary PCI is widely available. It has further been suggested that, given the relatively low volume of primary PCI procedures at some hospitals, the addition of other PCI procedures (including

elective PCI and PCI for acute coronary syndromes without ST-segment elevation) could help sustain and improve these programs.

In addition, previous studies have shown that, for patients with acute coronary syndromes presenting to centers without any revascularization capability, appropriate use of PCI and CABG is limited and outcomes are suboptimal.[5-7] Extension of PCI capability to such hospitals could improve access to appropriate care, particularly in areas where recruitment and retention of cardiologists may be difficult[8] and treatment options for patients are limited.

The Cardiovascular Patient Outcomes Research Team (CPORT) Non-Primary PCI (CPORT-E) trial was designed to help address these issues. CPORT-E was a randomized noninferiority trial that compared outcomes of PCI procedures (excluding primary PCI) at hospitals with and those without on-site cardiac surgery.

The CPORT-E trial was designed by the study chairman and the protocol-development committee and was funded through financial support provided by participating sites to the Johns Hopkins University and through in-kind support that included the provision of local study coordinators at each site. There was no support from the makers of equipment used in catheterization laboratories or of that used for PCI. The protocol was approved by each participating hospital's institutional review board and the Johns Hopkins institutional review board. Data were gathered by local research coordinators, reviewed for accuracy by central study coordinators at Johns Hopkins, and analyzed by the authors. The authors vouch for the accuracy and completeness of the data and the analysis and for the fidelity of this report to the trial protocol, which is available with the full text of this article at NEJM.org.

Patients were eligible for participation in the trial if they presented for diagnostic cardiac catheterization at 1 of 60 participating hospitals without on-site cardiac surgery located in 10 U.S. states (Maryland, New Jersey, Pennsylvania, Ohio, Georgia, Texas, North Carolina, Illinois, Oregon, and Alabama). During the trial period, patients who did not undergo randomization, whether or not they met the inclusion criteria for the trial, were included in a registry that recorded a limited set of data that excluded identifying private information.

Patients 18 years of age or older with stable coronary artery disease or an acute coronary syndrome were included in the trial. Patients with an acute myocardial infarction with ST-segment elevation were excluded, as were those with an ejection fraction of less than 20% and those who required PCI of an unprotected lesion in the left main coronary artery. In addition, interventionalists could exclude any patient whom they deemed to be at too high a risk for PCI. For each trial participant, all lesions requiring PCI had to be considered treatable at the hospital without on-site cardiac surgery before randomization. Patients who had previously participated in the trial were excluded. Full inclusion and exclusion criteria are available in Table S1 in the Supplementary Appendix, available at NEJM.org.

Interventionalists were required to meet criteria for competency developed by the American College of Cardiology (ACC), the American Heart Association (AHA), and the Society for Cardiac Angiography and Interventions (SCAI).[9] Participating centers were required to have primary PCI programs available 24 hours per day, 7 days per week, and to be capable of performing 200 PCI procedures annually. Most sites required a waiver from the state department of health to participate. All such waivers allowed for a first-year PCI volume of 100 procedures, increasing to 200 in the second year.

Each site had a formal agreement with a tertiary-care hospital partner specifying that the tertiary-care institution would accept emergency transfers from the enrolling site. However, participants in the trial who were randomly assigned to undergo PCI at a hospital with on-site surgery could have the PCI procedure at any tertiary-care hospital. A formal agreement with an advanced cardiac life-support service capable of transporting patients requiring intraaortic balloon counterpulsation was also required, with an anticipated response time of 30 minutes or less.

Before commencing recruitment, all participating sites were required to complete a formal PCI development program. This program included the development of detailed care plans and pathways, order sets, and logistics and the training of staff in the care of patients undergoing PCI. Details of this program are available in the Supplementary Appendix.

Before undergoing diagnostic catheterization, study participants provided written informed consent. After catheterization, if PCI was required and all lesions were considered to be treatable at the hospital without on-site cardiac surgery, the participant was randomly assigned in a 3:1 ratio to undergo PCI at either the enrolling site (without on-site cardiac surgery) or another facility with on-site cardiac surgery. Randomization was performed with the use of an automated telephone-response system on a per-site basis in random permuted blocks (of 4, 8, or 12). Patients who were considered to be at too high a risk according to the study-exclusion criteria or in the judgment of the treating physician did not undergo randomization but instead underwent PCI, CABG, or other therapy as clinically indicated.

After randomization, all trial participants were to undergo PCI according to their randomized assignment. The timing of the index PCI procedure depended on individual case acuity, the need to perform PCI on a different day than the visit to the catheterization laboratory to minimize procedural risk (i.e., staged procedure), and scheduling and transportation constraints, but the procedure was to be performed as soon as possible for each participant. All treatments, devices, and drugs were administered and laboratory studies carried out according to routine practice; no specific PCI protocol was prescribed. However, the use of cutting balloons was limited to in-stent restenosis and atherectomy devices were not permitted at hospitals without on-site cardiac surgery.

Participants were contacted by telephone (or mail, if necessary) at 6 weeks and 3, 6, and 9 months after study entry to identify adverse events. Medical records required to document identified events were obtained as needed.

Two coprimary outcomes were identified: all-cause mortality 6 weeks after the index PCI and the composite rate of major adverse cardiac events, including death from all causes, Q-wave myocardial infarction, and target-vessel revascularization, 9 months after the index PCI. Additional outcomes included the PCI success rate and the incidence of cardiac surgery, bleeding, stroke, renal failure, and any subsequent revascularization.

Except as noted, definitions of data elements followed those in the American College of Cardiology National Cardiovascular Data Registry module on cardiac catheterization, version 3.02.[10] Q-wave myocardial infarction was defined as the development of new Q waves in any two contiguous leads. Target-vessel revascularization was defined as any revascularization intervention (PCI or CABG) occurring in a treated vessel at any time after the index intervention. In randomly assigned participants who did not undergo an index PCI, any revascularization was considered a target-vessel revascularization. Bleeding was defined as any bleeding that required blood transfusion, except for transfusions associated with cardiac surgery. Vascular repair included thrombin injection, ultrasound-guided compression, and surgical repair. Further details of study definitions are available in the Supplementary Appendix.

All events were reported by the enrolling site to the central coordinating center and were confirmed by coordinating-center staff with the source medical records submitted. Occasionally, a review of source documents resulted in the identification of unreported events or the withdrawal of submitted events. A central review committee reviewed electrocardiographic findings without knowledge of the participant's randomized assignment.

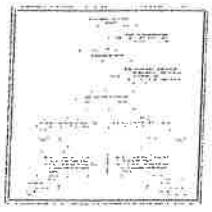
The CPORT-E trial was designed as a noninferiority trial. On the basis of previous studies, the 6-week all-cause mortality rate was estimated at 0.8%[11,12] and the rate of major adverse cardiac events at 9 months was estimated at 12.0%.[13-16] Noninferiority margins for the difference in event rates were set at 0.4 percentage points for the 6-week end point and 1.8 percentage points for the 9-month end point. With dual primary end points, the required number of participants for a one-sided test for noninferiority with an alpha level of 0.05 and a beta level of 0.80 was determined to be 18,360.

The primary outcome analysis was performed on data from the intention-to-treat population. Asymptotic normal approximations to the sample proportions were used to generate confidence intervals and P values for noninferiority. Categorical variables were compared with the use of Fisher's exact test or a chi-square test. A per-protocol analysis was also performed, which included only participants who underwent PCI at the site to which they were assigned. All statistical analyses were performed with the use of SAS software, version 9.2.

States that required a waiver from the department of health for trial participation typically specified that the participating hospitals should stop performing PCI when trial enrollment was completed. To allow the creation of a follow-up registry in these states, enrollment continued after the recruitment goal of 18,360 participants was reached. Ultimately, 18,867 participants underwent randomization.

Enrollment began on April 7, 2006, and ended on March 31, 2011. During that period, there were 99,479 patient visits for diagnostic catheterization at the participating hospitals. Among the 76.1% of patients who provided consent to participate, 21,165 were judged to require PCI after catheterization, and 18,867 underwent randomization (Figure 1). Excluded were 2298 patients (10.9%) who required PCI but were judged to be at too high a risk for study participation. Reasons for the judgment that the risk was too high are shown in Fig. S1 in the Supplementary Appendix. Overall, patients in the registry had fewer risk factors and less severe coronary disease than randomly assigned trial participants (Table S2 in the Supplementary Appendix).

FIGURE 1



Of the patients who underwent randomization, 319 did not undergo an index PCI. The proportion of patients who did not undergo an index PCI was higher among participants assigned to hospitals with on-site cardiac surgery than among those assigned to hospitals without on-site surgery. Reasons included referral for surgical or medical therapy and lesion resolution (Table S3 in the Supplementary Appendix).

Crossovers between study groups were infrequent but were more frequent among participants randomly assigned to hospitals with on-site cardiac surgery (Figure 1).

Enrollment and Randomization of the Study Patients.

The baseline characteristics of the participants are shown in Table 1. There was a higher incidence of prior PCI in participants randomly assigned to hospitals without cardiac surgery on site. In addition, the rate of emergency catheterization was higher, and the rate of urgent catheterizations lower, among participants assigned to hospitals with on-site cardiac surgery.

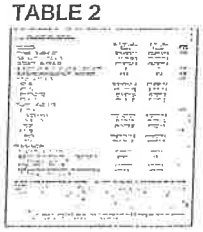
TABLE 1

Baseline Characteristics of the Study Patients.

The median annual volume of catheterizations per hospital was 150 procedures (interquartile range, 99 to 216). The median annual volume of primary PCIs was 51 procedures (interquartile range, 35 to 74). The participation of 12 hospitals was terminated during the trial because of low volume. Data from these sites were included in the data analysis.

A higher percentage of PCIs were staged among participants assigned to hospitals with on-site cardiac surgery than among those assigned to hospitals without on-site surgery, probably because of the need for transfer (Table 2). As a result, the number of visits to the catheterization laboratory that were needed to complete PCI was higher among participants assigned to hospitals with on-site cardiac surgery. In addition, drug-eluting stents were used more frequently in hospitals with on-site cardiac surgery.

TABLE 2

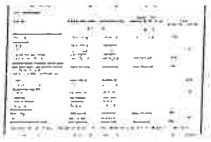


Characteristics of the Index Procedure.

The rate of PCI failure was lower among participants treated at hospitals with on-site cardiac surgery (Table 2). Emergency CABG was associated with high mortality but was rarely performed; it was performed more frequently among participants assigned to hospitals with on-site cardiac surgery. The incidence of unplanned re-catheterization and PCI before discharge was greater at hospitals without on-site cardiac surgery.

At 6 weeks after the index PCI, 132 participants assigned to hospitals without on-site cardiac surgery had died and 46 participants assigned to hospitals with on-site cardiac surgery had died. The event rates in the two groups were 0.9% and 1.0%, respectively (difference in event rates, −0.04 percentage points; 95% confidence interval [CI], −0.31 to 0.23; P=0.004 for noninferiority) (Table 3).

TABLE 3



Trial Outcomes.

At 9 months, there were 1716 major adverse cardiac events in participants at hospitals without on-site cardiac surgery and 529 such events in patients at hospitals with on-site cardiac surgery (12.1% vs. 11.2%; difference in event rates, 0.92 percentage points; 95% CI, 0.04 to 1.80; P=0.05 for noninferiority) (Table 3). There were no significant differences in all-cause mortality or Q-wave myocardial infarction between the two groups, but there was a significant difference in the rate of target-vessel revascularization — 6.5% among participants at hospitals without on-site cardiac surgery versus 5.4% among those at hospitals with on-site cardiac surgery (P=0.01).

Several exploratory analyses were conducted (Table 3). If CABG was not considered to qualify as target-vessel revascularization when it was performed as an initial procedure (i.e., for participants who did not undergo the intended index PCI), the rates of major adverse cardiac events at 9 months among participants at hospitals without and those with on-site cardiac surgery were 11.9% and 10.5%, respectively. In per-protocol analyses (excluding participants who crossed over), the death rates at 6 weeks were 0.9% and 0.8%, respectively, and the rates of major adverse cardiac events at 9 months were 12.0% and 10.4%, respectively.

CABG was performed more frequently among trial participants at hospitals with on-site cardiac surgery than among participants at hospitals without such access (Table 4). The incidence of unplanned catheterization at 6 weeks and 9 months and the incidence of any subsequent revascularization at 9 months were higher among participants at hospitals without on-site cardiac surgery (Table 4).

TABLE 4

Adverse Events.

We compared clinical outcomes between trial participants undergoing PCI at a hospital with on-site access to cardiac surgery and participants undergoing PCI at a hospital without such access. We found that outcomes at hospitals without on-site cardiac surgery were noninferior to those at hospitals with cardiac surgery on site, with respect to all-cause mortality at 6 weeks and major adverse cardiac events at 9 months. There were no significant differences between the two study groups at 9 months with respect to rates of death or Q-wave myocardial infarction, but trial participants treated at hospitals without on-site cardiac surgery more frequently required target-vessel revascularization.

The short-term results from this trial are concordant with the findings in previous registry studies and meta-analyses.[17,18] The longer-term outcomes are similar to those in a small randomized trial of low-risk PCI at two hospitals,[19] which showed equivalent

safety at the hospitals with and those without on-site cardiac surgery but more frequent target-vessel revascularization at 6 months among participants treated at the sites without cardiac surgery.

The definition of target-vessel revascularization used in the CPORT-E trial included any revascularization (PCI or CABG) after the index PCI. In addition, for randomly assigned participants who did not undergo an index PCI, any subsequent revascularization of the target vessel, whether by PCI or CABG, was considered a target-vessel revascularization. The inclusion of initial CABG as a target-vessel revascularization is consistent with the intention-to-treat approach, which is based on randomized treatment assignments, regardless of the treatment received. When CABG was not counted as a target-vessel revascularization in these trial participants, hospitals without on-site cardiac surgery were inferior to those with on-site access with respect to the rate of major adverse cardiac events at 9 months (Table 3). The per-protocol analysis also showed a higher rate of major adverse cardiac events in hospitals without on-site cardiac surgery. These differences are small and within the range of noninferiority margins used in recent comparative trials of stent types, from 1.5 percentage points (relative difference, 19%)[20] to 3.5 percentage points (relative difference, 43%).[21]

In all analyses, the rate of target-vessel revascularization was higher among participants who underwent PCI at a hospital without cardiac surgery on-site, regardless of the definition of target-vessel revascularization and regardless of stent type. The reason for this is not clear from the current study but may reflect a lower initial success rate and a more conservative approach by interventionalists practicing at relatively inexperienced centers that began PCI programs only as part of the CPORT-E trial.

There are a number of important limitations arising from the design and conduct of the CPORT-E trial. Participants were carefully selected and were excluded if they were deemed to be at high risk. It is possible that the population studied is different from the general population requiring PCI, although a comparison of baseline characteristics with those reported in the National Cardiovascular Data Registry[17] suggests that this is not the case (Table S4 in the Supplementary Appendix). For outcomes of PCI at hospitals without on-site cardiac surgery to be similar to those at hospitals with on-site cardiac surgery, it may be necessary for such centers to participate in a formal PCI development program and for interventionalists who perform the procedures to meet the criteria for competency developed by the ACC, AHA, and SCAI.

In summary, the CPORT-E trial compared the clinical outcomes of PCI performed at hospitals with access to on-site cardiac surgery with outcomes of PCI performed at hospitals without such access. Outcomes at hospitals without on-site cardiac surgery were noninferior to those at hospitals with cardiac surgery on site, with respect to all-cause mortality at 6 weeks and major adverse cardiac events at 9 months.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

This article (10.1056/NEJMoa1114540) was published on March 25, 2012, and updated on March 26, 2012, at NEJM.org.

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From Johns Hopkins University, Baltimore (T.A., C.C.L.); and Clinical Trials and Surveys, Owings Mills, MD (L.L.).

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HRSA U. S. Department of Health and Human Services
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Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Bradley County
Hamilton County
ID #: All

Results: 25 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Bradley County					
Cleveland Division Service Area	03253	MUA	43.20	1994/05/12	
MCD (90392) District 3					
MCD (90772) District 5					
MCD (90962) District 6					
MCD (91152) District 7					
Hamilton County					
Hamilton Service Area	03244	MUA	56.43	1982/06/03	1994/05/04
CT 0004.00					
CT 0006.00					
CT 0008.00					
CT 0011.00					
CT 0012.00					
CT 0013.00					
CT 0014.00					
CT 0016.00					
CT 0018.00					
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CT 0025.00					
CT 0026.00					
CT 0031.00					
CT 0122.00					
CT 0123.00					
CT 0124.00					

NEW SEARCH MODIFY SEARCH CRITERIA

U. S. Department of Health & Human Services

HRSA U. S. Department of Health and Human Services
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Find Shortage Areas: MUA/P by State and County

Shortage Designation Home
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HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Georgia
County: Catoosa County
ID#: All

Results: 2 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Catoosa County					
Catoosa Springs Service Area	00740	MUA	57.50	1994/05/10	
MCD (90582) Catoosa Springs CCD					

NEW SEARCH MODIFY SEARCH CRITERIA

Origination Date: ___ Approval: ___		A – 91
Reviewed/ Revised Date:	Effective Date:	Approval:

Erlanger Health System Policy and Procedure

Index Title: Guidelines for Cardiac Procedures Scheduled at Erlanger East Cath Lab
Originating Department: Cardiac Cath Lab/Cardiovascular Services
Number: PC-

Policy statement: Recommendations outlining the protocol and steps, based on ACC guidelines, that will be taken to ensure high risk or unstable patients are not catheterized at Erlanger East.

Scope: Interventional and Non Interventional Cardiologists, Cardiac Cath Lab Staff, Cardiovascular Services

Definitions:
PCI- Percutaneous Coronary Intervention
CHF- Congestive Heart Failure
LVEF- Left Ventricular Ejection Fraction

Procedure Protocol:

I. Pre Procedure

- Only patients that are considered "low risk" or that have minimal likelihood of coronary artery disease are to be scheduled for cardiac catheterization procedures at Erlanger East.
- A Cardiologist will determine the appropriateness/risk of the procedure prior to scheduling at Erlanger East.
- Procedures will be performed based on ACC guidelines for off-site surgical backup facilities.

II. High-Risk Patients Unsuitable for PCI at Facilities without on-site Cardiac Surgery

- Decompensated CHF without evidence for active ischemia
- Recent (<8 weeks) cerebrovascular accident
- Advanced malignancy
- Known Clotting Disorders
- LVEF< 30%

- Chronic Kidney Disease (Creatinine >2.0 mg/dl)
- Ongoing Ventricular Arrhythmias
- Known >50% Left Main Stenosis or three-vessel disease unprotected by bypass surgery
- Patients with single target lesion that jeopardizes a large area of the myocardium

III. PCI Case Selection/ACC Recommendations

PCI will avoided in patients with:

- >50% diameter stenosis of left main
- Long, calcified lesions at high risk for PCI failure
- Lesions in multiple vessels
- Lesions with TIMI 3 flow in patients with left main or three-vessel disease where bypass surgery would be of more benefit to the patient
- Culprit lesions in distal branches that by performing a PCI may cause or worsen more proximal lesions
- Chronic total occlusions
- Moderate to severely calcified lesions
- Older vein grafts
- Substantial thrombus in the vessel or lesion site
- Probable need for rotational or other atherectomy device

Committee	Approval/Date

Medical Director	Approval/Date

References:

Dehmer GJ, Blankenship JC, Cilingiroglu M, Dwyer JG, Feldman DN, Gardner TJ, Grines CL, Singh M. SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup. Catheterization and Cardiovascular Interventions, February 2014

Origination Date: 01/02/2015 Approval: _____		
Reviewed/ Revised Date:	Effective Date:	A – 93

Erlanger Health System Policy and Procedure

Index Title: Transfer Plan for patients having an elective Cardiac Catherization with possible PCI procedure at the EHS East facility without on-site surgical backup

Originating Department: Cardiovascular Services

Number: PC-

Policy statement: Transfer protocol in the event of a procedural complication which would warrant emergent or surgical intervention requiring transport to EHS main campus to provide cardiac surgical support. This also includes the transfer of non-emergent patients to EHS main campus requiring complex or PCI interventional procedures not available at the EHS East facility.

Scope: Cardiovascular Services, Interventional cardiologist, Cardiac Cath Lab staff (CCL), Emergency Department (ED), Emergency Medical Services (EMS), and Patient Logistics

Definitions:
EHS- Erlanger Health System
EMS- Emergency Medical Services
CCL- Cardiac Catheterization Laboratory
ED- Emergency Department
PCI- Percutaneous Coronary Intervention
IABP- Intra-aortic balloon pump
ACLS- Advanced Cardiac Life Support
TC- Transfer Center
RN- Registered Nurse
RRT- Registered Respiratory Therapist
RT- Radiology Technician

Procedure Protocol:

I. Pre-Procedure

- Prior to an elective outpatient cardiac procedure that will be performed at the EHS East facility the patient, family members and/or appropriate consenting party will be made aware that they made need to be transferred to the EHS main campus for further evaluation and treatment in the event that their condition warrants cardiac surgical support or a PCI procedure not available at the EHS East facility.

II. Transfer

- The patient requiring an emergent or PCI procedure not available at the EHS East facility will be accepted to the EHS main campus regardless of facility availability and/or staff resources.

- Patient Logistics/Transfer Center (Ext 8100) will be notified by the CCL staff of all patients that are being transferred from the EHS East facility and begin the process of bed assignment for the patient according to patient status.

- In the event of a patient condition requiring emergent/immediate transfer or a stable non-emergent transfer to EHS main campus, Puckett EMS will be contacted for patient transport per the CCL staff by calling (423-894-1800). Every effort will be made to ensure arrival of the patient to EHS main campus within 60 minutes of decision to transfer the patient. If Puckett EMS is not able to be available on-site in 6 minutes, they will then as per Puckett EMS policy and agreement with EHS contact another EMS service for mutual aid transport.

- The transporting EMS service will have available and/or be able to accommodate the following: portable cardiac ECG and pressure monitoring, sufficient O2 supply, suction, multiple drips, ACLS drugs, resuscitation equipment, defibrillator and IABP.

- The transport team will include paramedics, RN, RRT and CCL personnel with IABP expertise as needed. All members of the team should be ACLS certified.

- In the patient requiring emergent surgical intervention, the interventional cardiologist will contact the cardiovascular surgeon with the appropriate patient information and the need for surgical intervention.

Committee	Approval/Date

Medical Director	Approval/Date

References:

1. Dehmer GJ, Blankenship JC, Cilingiroglu M, Dwyer JG, Feldman DN, Gardner TJ, Grines CL, Singh M. SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup. Catheterization and Cardiovascular Interventions, February 2014

Quality Control and Monitoring for Erlanger East Cath Lab

These steps will be taken and documented to ensure quality control and procedure/patient monitoring is carefully followed:

- Comprehensive Documentation of Indications for PCI
- Appropriate Indication for Elective PCI
- Assessment of Candidacy for Dual-Antiplatlet Therapy
- Use of Embolic Protections Devices in the Treatment of Saphenous Vein Bypass Graft Disease
- Documentation of Preprocedural Glomerular Filtration Rate and Contrast Dose Used During the Procedure
- Radiation Dose Documentation
- Postprocedural Optimal Medical Therapy Composite (percentage of patients ≥ 18 for whom PCI is performed who are prescribed optimal medical therapy at discharge)
- Cardiac Rehabilitation Patient Referral Documentation and Tracking
- Regional/National PCI Registry Participant (NCDR Cath/PCI and ACTION)
- Annual Operator PCI Volume
- Annual Hospital PCI Volume
- Monthly Cath Lab Quality meetings, including Interventional Cardiologist, Cardiac Service Line and the Chief of Cardiology, will be held to discuss concerns and/or complications with cardiac cath lab procedures and patient outcomes.

References:

ACC indicates American College of Cardiology; AHA, American Heart Association; AMA-PCPI, American Medical Association–Physician Consortium for Performance Improvement; NCQA, National Committee for Quality Assurance; PCI,
percutaneous coronary intervention; and SCAI, Society for Cardiovascular Angiography and Interventions.
*For comprehensive information on these measures, including measure exceptions, please refer to the complete ACC/AHA/AMA-PCPI/NCQA/SCAI performance measurement specifications through the PCPI Web site (http://www.amaassn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI).

Origination Date:		
Approval:		
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12/05		
	1/09	
5/11		
	6/12	
	1/13	

Erlanger Health System Policy and Procedure

Index Title: Emergency Response on Erlanger Baroness Campus
Originating Department: Administration
Number: 8316.951
Description for EHS Intranet: Emergency; Emergency Response; Off campus emergencies;

Policy statement: Erlanger Health System (EHS) provides this policy and process to determine who should respond when an emergency situation occurs on the Baroness Campus, and designated adjacent areas.

Scope: EHS employees within Baroness Campus.

Procedure:

When an emergency situation occurs within Baroness Campus / Miller Eye Center or any location on the ground or first floor of the Medical Mall, a Code Blue, Code 5 or Rapid Response call should be made.

Emergency situations that occur on adjacent grounds, e.g. driveways, parking lots, Whitehall Building, Fillauer Building, UT Family Practice, E kids, Lincoln Park Building and any area not described above should contact 911. For additional medical expertise, the House Supervisor (HS) may be contacted.

Independent Physician Practices are not part of the Hospital and should be considered as adjacent grounds. For these areas, contact 911 in emergency situations.

The HS can be immediately contacted by dialing 778-6911. After assessing the nature of the emergency, while waiting for a response, the appropriate first aid care, CPR (Cardiopulmonary Resuscitation), containment of bleeding and/or comfort measures are to be offered. This care must be consistent with good medical practice (which may mean, "doing no harm" and not moving the person). The HS will determine the level of response required for emergency/medical situations after considering the following:

- Personal safety of the responding personnel.
- Availability of medically trained staff who could be dispatched to the location.
- Status/need of current and waiting patients, in that the medical care of these individuals will not be delayed or impaired by having emergency personnel dispatched to another location.

- Availability of portable medical equipment and supplies to be transported by emergency medical personnel to the location.

The Rapid Response Nurse (7789) may be called on to serve as the back up for the HS, should the HS be unavailable.

The HS will put the Emergency Department on stand-by for additional stabilizing and packaging equipment, including transport needs via stretcher.

See CPR Adult Code Blue Process, PC.120.
See CPR Pediatric Code 5 Process, 6012.08

Committee	Approval/Date
Legal	6/12
Code Committee	6/12

Medical Director	Approval/Date

References:

Erlanger Health System Policy and Procedure

Origination Date: 02/11/09		
Approval:		
Reviewed Date:	Revised Date:	Approval:
4/18/112/2013		7/2014

Index Title: Non-EmergentHospitalOutpatient Order Policy
Originating Department: Patient Access
Number: 6316.1035
Description for EHS Intranet: Outpatient Orders

Policy Statement: Erlanger Health System (EHS) requires a complete and valid physician outpatient order prior to non-emergent hospital services being rendered.

Purpose: To establish guidelines outlining the documentation required for all non-emergent outpatient services orders submitted in accordance with payer guidelines. This policy should be used in conjunction with the Non-Covered Services Policy and the Medical Necessity Policy.

Scope: All non-emergent outpatient services provided by an outpatient department of Erlanger Health System.

Exceptions: Exceptions to this policy applicable to Medicare patients include the following services for which Medicare does not require a documented order:

- Screening mammography;
- Pneumococcal pneumonia vaccine (PPV) and its administration;
- Influenza vaccine and its administration.

Definitions:

Authentication: The requirement of a written signature or a computer-secure entry by a unique identifier of a primary author who has approved the entry.

Advance Beneficiary Notice (ABN): An ABN is a written notice given to a Medicare Beneficiary before Part B services are furnished when Erlanger Health System believes that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary (i.e., under §1862(a)(1) of the Act) and Erlanger Health System (EHS) wishes to bill the patient for the provided services. The information in the ABN will assist the beneficiary in making an informed decision whether or not to receive the service and be financially responsible for the payment.

Deferral of Hospital Outpatient Services: The deferral or re-scheduling of services until the receipt of a complete and valid physician order and the financial requirements being met.

Medical Necessity: Items or services which may be justified as reasonable, necessary, and/or

appropriate, based on evidence-based clinical standards of care.

Modification of Orders: Existing orders may not be changed by EHS personnel. Any change or addition to a service or test embodied in an existing order requires that the procedures noted in the "Modification of Outpatient Orders" section of this policy be followed.

Non-Physician Practitioner ("NPP"): An NPP can be a physician assistant, clinical psychologist, nurse practitioner, clinical nurse specialists, licensed clinical social worker, or certified nurse midwife acting within his/her state scope of practice laws and hospital-granted privileges.

Outpatient Laboratory Requisition: A computer generated document listing outpatient tests that are available for a Physician to order. It can serve as evidence of the services the Physician intended to order if it is also adequately documented in the medical record and authenticated.

Order Sets: An order that outlines a treatment regime or standard of care required for a patient having a specifically-defined type of care / treatment (i.e., AHCPR protocol for treatment of pressure ulcers). Special Note: Orders for outpatient services may be supported by a valid, approved hospital order set that has been initiated by a physician or NPP and approved by the hospital's Medical Staff. A copy of the order set must be maintained in the patient's medical records.

Recurring Orders: A physician may submit an order for tests, injections, lab, infusions, etc., to be performed on a recurring basis. The recurring order must include all elements as outlined in theoutpatient order elements noted below in this policy, including:

- Frequency of the test, etc. to be performed (such as monthly, weekly,bi-weekly, etc.)
- The length of time that the order is to re-occur and is valid(such as 6 weeks, 2 weeks, 3 months, etc.) Most will be updated every six months – however, a Recurring Order may be valid beyond 6 months or less / more than this time period based on time specifications of the physician as the duration of the patient's specific treatment period, not to exceed twelve months.
- Number of treatments to be provided (such as 10 HBO TX, etc.)
- Must be medically necessary

Treating physician: A physician, as defined in §1861 (r) of the Social Security Act (the Act), who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results of a diagnostic test in the management of the beneficiary's specific medical problem.

PROCEDURES:

The following are the required data elements for Non-Emergent Hospital Outpatient Orders:

1. Patient Legal Name;
2. Patient date of birth;
3. Reason for ordering the test or service (i.e., diagnosis description signs or symptoms);

4. Physician or qualified health professional authentication "signature";
5. Name of ordering practitioner;
6. Date of order (Date provider signed the order).

A complete and valid physician order contains the above elements. When the above elements are present and all other coverage guidelines are met, the hospital may provide and subsequently bill for the services ordered once performed.

Special Note: An acceptable order should not include such diagnosis language as:

- Rule/Out (R/O)
- Possible
- Suspicious
- Probable

A complete and valid physician order should be secured for all non-emergent outpatient services at least 48 hours prior to the patient's date of serviceby responsible registration and scheduling personnel.

All non-emergent outpatient services scheduled without a complete and valid order 48 hours prior to the patient's date of service will be escalated by Patient Access. The physician or physician's office personnel will be contacted via telephone and email notifying them that the service will be deferred due to the lack of a valid order. Once notified, the physician's office must supply a valid order that contains all of the required elements no later than 24 hours prior to scheduled appointment to prevent the service from being deferred and rescheduled.

Unscheduled or walk-in patients must arrive at registration with a complete and valid physician order. Patient Access, Registration or other responsible personnel receiving an incomplete order must call the physician office and request the required information. The physician office must furnish a new order for any unscheduled or walk-in patients arriving at registration without a complete and valid order prior to the services being provided. Unscheduled or walk-in patients may experience extended wait times pending receipt of a complete and valid order, verification of patient insurance policy requirements related to pre-certification or pre-authorization of services prior to services being rendered.

Every effort should be made to obtain all required information prior to services being rendered. For Medicare and Medicaid patients, the Center for Medicare & Medicaid Services guidelines state that if patient care or the integrity of a specimen is at risk, you should continue processing the test (s) or performing service (s) and subsequently obtain the required elements. This requires clinical judgment and should be discussed with appropriate supervisor(s).

All Patient Access registration departments are responsible for scanning the complete and valid physician order into HPF in order for the order to become a part of the patient's medical record.

If any of the required outpatient order data elements noted above are missing, a new order will be **REQUIRED** directly from the physician prior to the services being performed.

Verbal orders will notbe accepted for non-emergent hospital outpatient services.

Modification of Order:

As noted above, every effort should be made to obtain all required information prior to non-emergent outpatient services being provided. Patient Access, Registration or other personnel receiving an incomplete order must call the physician office and request that the physician office furnish a new and valid order prior to the services being provided.

If patient services were rendered with an incomplete order (i.e. missing or incorrect Dx),the physician can make an entry to clarify/correct this by amending the patient's medical record, documenting the missing data element and / or reason for the correction and providing us with a copy of the amended patient record. If an order for a clinical diagnostic service is missing the provider's authentication, you may rely on a copy of the patient's medical record if it already has documentation of the provider's intent to order the services and the medical record had beenpreviously authenticated. Please note that this should be the exception not the rule.

Implementation:

1. EHS must ensure all outpatient orders, whether paper-based or generated through web-based physician portals, meet the requirements of this policy.

2. EHS must have a process in place to ensure staff and Physicians are notified of the requirements of this policy.

Annual Review:

This policy and related supporting documents are subject to annual review by the Patient Access Department and members of the Revenue Cycle Committee, including the Office of Compliance.

Enforcement:

All EHS personnel whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Those employees who fail to comply with this policy will be subject to appropriate disciplinary action pursuant to EHS' applicable policy and procedure, up to and including termination.

Committee	Approval/Date

References:
Medicare Conditions of Participation
42 C.F.R §482.23; §428.24; §428.26b.4
42 C.F.R §410.32
TJC (The Joint Commission) RC standards
TJC (The Joint Commission) MS 2.5
http://www.cms.gov/Medicare/Coding/ICD10/index.html
CMS Benefit Policy Manual (Pub 100.02) Transmittal 80
CMS "Medicare Program Integrity Manual" (Publication [Pub.] (100-08), Chapter 3, Section 3.4.
11. D
CMS, State Operations Manual Appendix A-Survey Protocol, Regulations, and Interpretive
Guidelines for Hospitals, Interpretive Guidelines §482.24(c) (1) (i) and (ii)
EHS Rules and Regulations of the Medical Staff (January 18, 2011)
EHS Bylaws of the Medical Staff (May 2010)
The ABN manual instructions and ABN Form CMS -R-131 are available at
http://www.cms.gov/ BNI/02_ABN.asp

Consolidated Interim Financial Statements

Quarter Ending December 31, 2014

This financial report is confidential and proprietary information. This document is not a public record until finalized and released by the chief financial officer. The embargo date for the information contained herein is January 19, 2015 at 5P.M. EST. No part of the information contained herein may be released or discussed publicly until this date.

ERLANGER HEALTH SYSTEM
Unaudited Consolidated Balance Sheets as of: December 31, 2014

ASSETS	2015	2014
UNRESTRICTED FUND		
CURRENT:		
Cash and temporary investments	$ 48,577,896	$ 11,479,109
Funds held by trustee - current portion	52,298	-
Patient accounts receivable	354,232,363	300,489,936
Less allowances for patient A/R	(276,421,074)	(211,524,959)
Net patient accounts receivable	77,811,289	88,964,977
Other receivables	38,167,740	35,129,267
Due from third party payors	21,793,236	8,713,165
Inventories	12,938,442	13,493,199
Prepaid expenses	7,040,384	8,418,132
Total current assets	206,381,285	166,197,850
PROPERTY, PLANT, AND EQUIPMENT		
Net property, plant and equipment	141,112,886	159,339,406
LONG-TERM INVESTMENTS	602,850	299,526
OTHER ASSETS:		
Assets whose use is limited	202,886,315	130,701,339
Deferred debt issue cost	1,980,398	5,527,115
Other assets	1,632,856	1,912,082
Total other assets	206,499,568	138,140,537
DEFERRED OUTFLOWS OF RESOURCES		
Deferred amounts from debt refunding	680,344	766,282
TOTAL	**$ 555,276,932**	**$ 464,743,601**

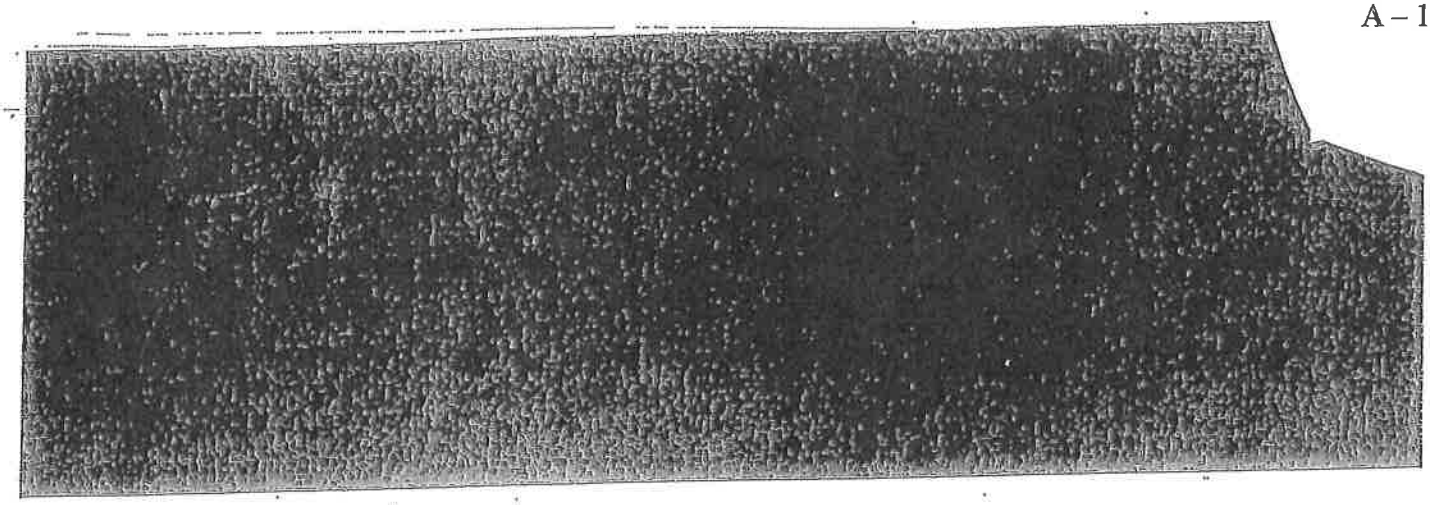
LIABILITIES	2015	2014
UNRESTRICTED FUND		
CURRENT:		
Current maturities of long term debt	$ 4,566,185	$ 10,787,271
Accounts payable	42,896,883	44,811,248
Accrued salaries & related liabilities	17,334,117	12,828,781
Due to third party payors	-	1,701,219
Construction fund payable	15,111	200,800
Accrued Interest payable	808,308	1,945,682
Total current liabilities	65,620,604	72,275,001
POST RETIREMENT BENEFITS (GASB 45 & FAS 112)	28,652,013	21,559,818
RESERVE FOR OTHER LIABILITIES	20,068,640	24,434,723
DEFERRED INFLOWS OF RESOURCES		
Deferred gain from sale-leaseback	3,935,725	4,400,481
LONG - TERM DEBT	228,436,439	160,104,352
FUND BALANCE:		
Unrestricted	287,148,347	162,393,922
Invested in capital assets, net of related debt	(83,662,041)	14,693,351
Restricted	5,077,206	4,881,953
	208,563,512	181,969,226
TOTAL	**$ 555,276,932**	**$ 464,743,601**

Erlanger Health System

Unaudited Consolidated Statement of Operations

For the quarter ended December 31, 2014 and 2013

	Current Quarter			Year to Date		
	Actual	Budget	Prior Year	Actual	Budget	Prior Year
Net patient service revenue	$ 166,290,317	$ 144,506,258	$ 140,025,215	$ 323,178,013	$ 291,886,021	$ 278,635,216
Other revenue(expense)	7,709,232	8,882,108	8,562,720	15,224,119	17,799,591	17,613,969
Net operating revenue	173,999,549	153,388,365	148,587,935	338,402,132	309,685,612	296,249,185
Expenses						
Salaries and employee benefits	83,452,576	83,056,989	77,524,744	167,388,892	166,828,178	158,345,641
Supplies	22,820,505	18,243,465	21,193,640	43,338,685	36,949,887	41,365,904
Purchased services	33,785,957	30,588,042	29,816,259	64,955,481	60,986,113	58,120,399
Utilities	2,186,592	2,389,590	2,287,680	5,005,112	4,829,213	5,053,965
Drugs	11,028,464	8,543,241	10,107,401	21,322,113	17,178,958	18,311,963
Depreciation	7,086,993	7,076,580	7,415,359	14,172,209	14,152,260	14,825,546
Insurance & taxes	894,328	959,335	1,062,397	1,752,879	1,845,000	1,741,932
Total operating expense	161,255,415	150,857,242	149,407,479	317,935,371	302,769,608	297,765,349
Excess rev. over/(under) exp. from operations	12,744,133	2,531,123	(819,544)	20,466,761	6,916,004	(1,516,165)
NONOPERATING INCOME:						
Gain (Losses) on disposal of assets	(217,162)	(54,161)	(83,879)	(166,783)	(108,322)	(140,077)
Interest Income/Gains (Losses) on Investments	258,446	338,210	540,140	350,306	676,420	937,501
Interest expense	(5,288,282)	(2,169,816)	(2,335,329)	(7,295,469)	(4,339,631)	(4,747,417)
Mark to market on swaps	6,997	-	473,977	693,533	-	1,042,265
Provisions for income tax	(24,279)	(3,380)	(1,770)	(157,830)	(25,030)	(20,890)
Excess rev. over/(under) expenses	$ 7,479,854	$ 641,977	$ (2,226,405)	$ 13,890,518	$ 3,119,441	$ (4,444,783)
Operating Margin	7.32%	1.65%	-0.55%	6.05%	2.23%	-0.51%
Total Margin	4.29%	0.42%	-1.82%	3.90%	1.01%	-1.85%



CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System and Discretely Presented Component Units)

Audited Combined Financial Statements

Years Ended June 30, 2014 and 2013

PYA
Certified Public Accountants

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Audited Combined Financial Statements

Years Ended June 30, 2014 and 2013

PERSHING YOAKLEY & ASSOCIATES,
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
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PYA
Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of
Chattanooga-Hamilton County Hospital Authority
(d/b/a Erlanger Health System):

Report on the Combined Financial Statements

We have audited the accompanying combined financial statements of the business-type activities of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) and its discretely presented component units, as of and for the years ended June 30, 2014 and 2013, and the related notes to the combined financial statements, which collectively comprise the Primary Health System's basic combined financial statements as listed in the table of contents.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Primary Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness

of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinions

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component units of the Primary Health System as of June 30, 2014 and 2013, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note A to the combined financial statements, during the year ended June 30, 2014, the Primary Health System adopted a newly issued accounting standard that requires retroactive adjustments to amounts previously reported as of and for the year ended June 30, 2013, with a cumulative effect adjustment to net position as of June 30, 2012. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information: Accounting principles generally accepted in the United States of America require that the management's discussion and analysis (shown on pages 3 through 11) be presented to supplement the basic combined financial statements. Such information, although not a part of the basic combined financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic combined financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic combined financial statements, and other knowledge we obtained during our audit of the basic combined financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
September 17, 2014

Management's Discussion and Analysis

MANAGEMENT'S DISCUSSION AND ANALYSIS

The discussion and analysis of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System's financial performance provides an overview of financial activities for the fiscal years ended June 30, 2014 and 2013.

Erlanger Health System (the Primary Health System) is the largest healthcare provider in Southeast Tennessee. The Primary Health System maintains a number of very specialized clinical services such as Level I trauma, Level III neonatal, kidney transplantation, a Regional Cancer Unit, a full service children's hospital, and open heart surgery, all of which are primarily serviced by four "Life Force" helicopters and supported by subspecialty physicians (residents, faculty and private attending physicians) located on its campuses.

OVERVIEW OF THE COMBINED FINANCIAL STATEMENTS

The combined financial statements consist of two parts: Management's Discussion and Analysis and the combined financial statements. The combined financial statements also include notes that explain in more detail some of the information in the combined financial statements.

The combined financial statements of the Primary Health System offer short-term and long-term financial information about its activities. The combined statements of net position include all of the Primary Health System's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to the Primary Health System's creditors (liabilities). The assets and liabilities are presented in a classified format, which distinguishes between current and long-term assets and liabilities. It also provides the basis for computing rate of return, evaluating the capital structure of the Primary Health System and assessing the liquidity and financial flexibility of the Primary Health System.

All of the fiscal year's revenues and expenses are accounted for in the combined statements of revenue, expenses, and changes in net position. These statements measure the success of the Primary Health System's operations and can be used to determine whether the Primary Health System has successfully recovered all of its costs through the services provided, as well as its profitability and credit worthiness.

The final required financial statement is the combined statements of cash flows. The primary purpose of these statements is to provide information about the Primary Health System's cash receipts, cash payments and net changes in cash resulting from operating, investing, non-capital financing and financing activities. The statements also provide answers to such questions as where did cash come from, what was cash used for, and what was the change in the cash balance during the reporting period?

The analyses of the combined financial statements of the Primary Health System begins on the next page. One of the most important questions asked about the Primary Health System's finances is "Is the financial condition of the Primary Health System as a whole better or worse as a result of the fiscal year's activities?" The combined statements of net position and the combined statements of revenue, expenses and changes in net position report information about the Primary Health System's activities in a way that will help answer this question. These two statements report the net position of the Primary Health System and changes in the net position. One can think of the Primary Health System's net position – the difference between assets and liabilities – as one way to measure financial health or financial position. Over time, increases or decreases in the Primary Health System's net position is one indicator of whether its financial health is improving or deteriorating. However, one will need to consider other non-financial factors such as changes in economic conditions, regulations and new or changed government legislation.

REPORTING ENTITY

The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by generally accepted accounting principles, these financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational, financial or other relationships with the Primary Health System.

ContinuCare HealthServices, Inc., Plaza Surgery, G.P., Cyberknife of Chattanooga, LLC (Cyberknife), UT-Erlanger Medical Group, Inc. (the Medical Group) and Erlanger Health Plan Trust are legally separate organizations for which the Primary Health System is either financially accountable or owns a majority interest. Accordingly, these organizations represent component units of the Primary Health System. The financial statements of Erlanger Health Plan Trust are blended with the financial statements of the Primary Health System, as the Board of Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

During 2012, the Primary Health System acquired 100% ownership in Plaza Surgery, G.P. As a result, Plaza Surgery, G.P.'s operations are no longer distinct from the Primary Health System. During fiscal year 2011, Cyberknife was capitalized by contributions from the Primary Health System and certain other minority partners. Cyberknife provides radiation therapy services, specifically robotic stereotactic radiosurgical services through the use of a Cyberknife stereotactic radiosurgery system on the Primary Health System's campus. At June 30, 2014,

2013 and 2012, the Primary Health System owned 51% of Cyberknife's outstanding membership units. The Medical Group was formed on June 30, 2011 and will provide professional healthcare and related services to the public through its employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Medical Group is currently not active.

KEY FINANCIAL INDICATORS

The following key financial indicators are for Erlanger Health System as a whole. They are inclusive of the Primary Health System, ContinuCare HealthServices, Inc., and the 51% controlling share of Cyberknife of Chattanooga, LLC.

- Excess revenues over expenses from operations for Erlanger Health System for the fiscal year 2014 is $18.0 million compared to excess expenses over revenues of $7.9 million for the fiscal year 2013 and excess expenses over revenues of $9.5 million for the fiscal year 2012.
- Total cash and investment reserves at June 30, 2014 are $139 million (excluding $31 million of funds held by Trustees or restricted by donors or others).
- Net days in accounts receivable for Erlanger Health System (utilizing a three month rolling average of net revenue) is 50 days at June 30, 2014 compared to 50 days at June 30, 2013 and 53 days at June 30, 2012.
- For fiscal year 2014, Erlanger Health System recognized $19.6 million in public hospital supplemental payments from the State of Tennessee.
- For fiscal year 2014, Erlanger Health System recognized $12.8 million in essential access payments from the State of Tennessee compare to $10.6 million in fiscal year 2013 and $11.4 million in fiscal year 2012.
- For fiscal year 2014, Erlanger Health System did not recognize disproportionate share payments from the State of Tennessee compared to $8.5 million in fiscal year 2013 and $9.2 million in fiscal year 2012.
- For fiscal year 2014, Erlanger Health System recognized $0.9 million in trauma fund payments from the State of Tennessee compared to $1.1 million in fiscal year 2013 and $1.0 million in fiscal year 2012.

- For fiscal year 2012, Erlanger Health System recognized $3.3 million in a Medicare rural floor budget neutrality settlement payment.

The required bond covenants ratios for fiscal year 2014 compared to bond requirements are as follows:

		Master	*Bond Insurer Requirements*		
	June 30, 2014	*Trust Indenture*	*98 Series*	*00 Series*	*04 Series*
Debt service coverage ratio	2.40	1.10	1.10	1.35	1.35
Cushion ratio	7.30	N/A	1.50	N/A	N/A
Current ratio	2.57	N/A	1.50	1.50	1.50
Days cash on hand	87	N/A	N/A	65 days	65 days
Indebtedness ratio	48%	N/A	N/A	N/A	65%
Operating cash flow margin	8%	N/A	N/A	5%	5%

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. For fiscal year 2014, Erlanger Health System met all required debt covenants. For fiscal year 2013, Erlanger Health System failed to satisfy the debt service coverage ratio required by one of the bond insurers. As a result of the non-compliance, the Primary Health System obtained a waiver from the bond insurer.

NET POSITION

Erlanger Health System's net position for the combined Primary Health System and Aggregate Discretely Presented Component Units increased by approximately $14 million in fiscal year 2014. Our analysis focuses on the net position (Table 1) and changes in net position (Table 2) of the Primary Health System's operating activities. Discussion focuses on the Primary Health System and its blended component units.

Net position for the Primary Health System increased from $182 million as of June 30, 2013 to $195 million as of June 30, 2014. The current ratio (current assets divided by current liabilities) increased from 2.25 in 2013 to 2.52 in 2014 for the Primary Health System.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2014 and 2013

Table 1- Net Position (in Millions)

	June 30, 2014		June 30, 2013		June 30, 2012 (before GASB 65 adoption)	
	Primary Health System	Discretely Presented Component Units	Primary Health System	Discretely Presented Component Units	Primary Health System	Discretely Presented Component Units
Current and other assets	$ 333	$ 12	$ 309	$ 12	$ 328	$ 12
Capital assets	149	9	161	10	158	10
Total assets	480	21	470	22	486	22
Deferred outflows of resources	1	-	1	-	-	-
	$ 481	$ 21	$ 471	$ 22	$ 486	$ 22
Long-term debt outstanding	$ 159	$ 3	$ 170	$ 3	$ 177	$ 4
Other liabilities	123	3	114	4	109	4
Total liabilities	282	6	284	8	286	8
Deferred inflows of resources	4	-	4	-	-	-
	$ 286	$ 6	$ 289	$ 8	$ 286	$ 8
Net position						
Net investment in capital assets	$ 1	$ 5	$ 10	$ 6	$ -	$ 5
Restricted, expendable	2	-	2	-	2	-
Unrestricted	191	9	170	8	198	9
Total net position	$ 194	$ 14	$ 182	$ 14	$ 200	$ 14

Days in cash increased from 73 days as of June 30, 2013 to 88 days as of June 30, 2014 for the Primary Health System resulting from increased operating margins combined with a $19.6 million public hospital supplemental payment received from the State of Tennessee in fiscal year 2014. Days in cash decreased from 81 days as of June 30, 2012 to 73 days as of June 30, 2013 for the Primary Health System due to decreased operating margins combined with a $8 million receivable for funds drawn on a line of credit extended to Hutcheson Medical Center, Inc. in fiscal year 2013.

Days in net accounts receivable were 51 days as of June 30, 2014 and June 30, 2013. Days in net accounts receivable decreased from 55 days as of June 30, 2012 to 51 days as of June 30, 2013.

Capital assets for the Primary Health System were $149 million as of June 30, 2014. Additions for fiscal year 2014 totaled $14 million while $5 million of assets were retired. Depreciation expense was $26 million for the Primary Health System. Retirement of assets reduced accumulated depreciation by $5 million in fiscal year 2014. Construction in progress was $5 million as of June 30, 2014. Included in construction in progress are Erlanger East development costs of $2.5 million.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2014 and 2013

Capital assets for the Primary Health System were $161 million as of June 30, 2013. Additions for fiscal year 2013 totaled $30 million while $4 million of assets were retired. Depreciation expense was $27 million for the Primary Health System. Retirement of assets reduced accumulated depreciation by $4 million in fiscal year 2013. Construction in progress was $9 million as of June 30, 2013. Included in construction in progress at June 30, 2013 are surgical suite expansion projects totaling $3.2 million

	Primary Health System		
	2014	*2013*	*2012*
Land and improvements	$ 26	$ 26	$ 25
Buildings	234	231	224
Equipment	377	367	351
Total	637	624	600
Less accumulated depreciation	(493)	(472)	(449)
Construction in progress	5	9	7
Net property, plant and equipment	$ 149	$ 161	$ 158

Long-term debt outstanding amounted to $159 million as of June 30, 2014 compared to $169 million as of June 30, 2013. The decrease in long-term debt reflects normal scheduled principal payments. Long-term debt outstanding amounted to $169 million as of June 30, 2013 compared to $177 million as of June 30, 2012. The decrease in long-term debt reflects normal scheduled principal payments.

Other liabilities for the Primary Health System were $123 million as of June 30, 2014, $119 million at June 30, 2013, compared to $108 million as of June 30, 2012.

CHANGES IN NET POSITION

The focus for Erlanger Health System's management team during fiscal year 2014 and 2013 was to increase the Primary Health System's volumes in a number of key product lines in a downturned economy, improve relationships with stakeholders, and improve operating efficiencies.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2014 and 2013

Table 2- Changes in Net Position (in Millions)

	June 30, 2014		June 30, 2013		June 30, 2012	
	Primary Health System	Discretely Presented Component Units	Primary Health System	Discretely Presented Component Units	Primary Health System	Discretely Presented Component Units
Net patient revenue	$ 571	$ 11	$ 526	$ 12	$ 514	$ 12
Other revenue	21	17	19	16	22	16
Total revenue	592	28	545	28	536	28
Expenses:						
Salaries	305	14	298	13	300	13
Supplies and other expenses	126	10	113	11	116	11
Purchased services	117	3	114	3	104	3
Depreciation and amortization	26	1	27	1	26	1
Total expenses	574	28	552	28	546	28
Operating income revenues in excess of (less than) expenses	18	1	(7)	-	(10)	-
Nonoperating gains	2	-	-	-	4	-
Interest expense and other	(9)	-	(7)	-	(11)	-
Operating/capital contributions	1	-	-	-	-	-
Change in net position	$ 12	$ 1	$ (14)	$ -	$ (17)	$ -

Net patient service revenue for the Primary Health System increased from $526 million in fiscal year 2013 to $571 million in fiscal year 2014. Admissions for fiscal year 2014 increased by 4.8% when compared to fiscal year 2013, while surgical mix increased over the prior year by 1.8%. The Erlanger East emergency room generated 15,900 additional emergency room visits compared to prior year.

Net patient service revenue for the Primary Health System increased from $514 million in fiscal year 2012 to $526 million in fiscal year 2013. Admissions for fiscal year 2013 were comparable to fiscal year 2012, however, case mix increased over the prior year by 1.6%. The Erlanger East emergency room opened in March 2013 generating 6,100 additional emergency room visits compared to prior year.

Salaries for the Primary Health System increased from $298 million in fiscal year 2013 to $305 million in fiscal year 2014. Staffing was in concert with the increased volumes. Paid FTE's per adjusted occupied bed decreased from 5.40 in fiscal year 2013 to 5.13 in fiscal year 2014, however, salary cost for fiscal year 2014 per hour increased by 2.2 % over the prior year. Inclement weather in January 2014 and February 2014 resulted in increased overtime wages. Salaries for the Primary Health System decreased from $300 million in fiscal year 2012 to $298 million in fiscal year 2013. Paid FTE's per adjusted occupied bed decreased from 5.60 in fiscal year 2012 to 5.40 in fiscal year 2013.

Supplies and other expenses increased from $113 million for fiscal year 2013 to $126 million in fiscal year 2014. Supplies and drug costs trended with the volume increases. Supplies and drugs per adjusted admission for the Primary Health System decreased from $1,587 in fiscal year 2013 to $1,555 in fiscal year 2014. Supplies and other expenses decreased from $116 million for fiscal year 2012 to $113 million for fiscal year 2013. Supplies and drugs per adjusted admission for the Primary Health System decreased from $1,675 in fiscal year 2012 to $1,587 in fiscal year 2013.

Purchased Services increased from $114 million in fiscal year 2013 to $117 million in fiscal year 2014 due primarily to the outsourcing of food and environmental services. Purchased Services increased from $104 million in fiscal year 2012 to $114 million in fiscal year 2013 due to contracted service expenditures assumed with the purchase of Plaza Surgery's minority interest, fees associated with the third party operational assessment and implementation, and an increase in rent expense resulting from the sale of the Erlanger East POB.

Depreciation and amortization expense decreased from $27 million in fiscal year 2013 to $26 million in fiscal year 2014 due to decreased capital spending. Depreciation and amortization expense increased from $26 million in fiscal year 2012 to $27 million in fiscal year 2013 due, in part, to the addition of the Erlanger East emergency room.

Interest expense, including gain (or loss) on mark-to-market of interest rate swaps, increased from $7 million in fiscal year 2013 to $9 million in fiscal year 2014. The market value of the liability for the mark-to-market of interest rate swaps increased by $.9 million in fiscal year 2014 compared to an increase of $2.3 million in fiscal year 2013. Interest expense, including gain (or loss) on mark-to-market of interest rate swaps, decreased from $11 million in fiscal year 2012 to $7 million in fiscal year 2013. The market value of the liability for the mark-to-market of interest rate swaps increased by $2.3 million in fiscal year 2013 compared to a decrease of $1.1 million in fiscal year 2012.

OUTLOOK

The State of Tennessee continues to review the TennCare program (the State's Medicaid program). For fiscal years 2012 and 2013, the State passed a Hospital Coverage Fee to offset shortfalls in the State's budget for TennCare. The fee remained intact and TennCare rates were stable in fiscal year 2014. There could be possible TennCare rate changes in fiscal year 2015 as a result of rate variation initiatives. Out-of-state Medicaid and TennCare changes would affect the Primary Health System's bottom line with TennCare and Medicaid patients representing approximately 22% of the payer mix. Self Pay patients represent approximately 10% of the charge utilization. Healthcare reform and future changes in Medicare regulations could also have an adverse effect on the Primary Health System's future operations since Medicare represents approximately 33% of the payer mix.

During fiscal year 2014, the Primary Health was added as a participant to the Public Hospital Supplemental Payment Pool for public hospitals in Tennessee through a collaborative effort with local Mayors, State Senators and Representatives, Hamilton County Medical Society, Board members, physicians and hospital leadership. The inclusion of the Primary Health System in the pool netted $19.6 million of additional federal funding for fiscal year 2014. The Primary Health System will receive this funding annually as long as the current TennCare waiver is intact.

The Primary Health System also secured a 5-year partnership agreement with BlueCross BlueShield of Tennessee (BCBST) to be the exclusive provider for new members under the health insurance exchange. BCBST is Tennessee's largest insurer and Chattanooga's largest provider. In addition to the exclusivity, the partnership included a $1M innovation grant and a combined marketing effort specifically aimed at major Chattanooga employers. The partnership provides for a more predictable, longer-term stable relationship with BCBST.

The Primary Health System recognized Essential Access payments totaling $12.8 million from the State of Tennessee for fiscal year 2014, an increase of $2.2 million from fiscal year 2013. Disproportionate share payments were not approved by Federal government for fiscal year 2014. The Primary Health System received Disproportionate Share Payments of $8.5 million in fiscal year 2013. The Primary Health System recognized Essential Access and Disproportionate Share payments totaling $19.1 million from the State of Tennessee for fiscal year 2013, a decrease of $1.5 million from fiscal year 2012. Additionally, the Primary Health System recognized trauma funding of $.9 million in fiscal year 2014 compared to $1.1 million in fiscal year 2013 and $1.0 million in fiscal year 2012. Payments from the State of Tennessee for the fiscal year 2015 are expected to be consistent with the fiscal year 2014. Due to the 1966 Hamilton County Sales Tax Agreement expiring in May 2011, the Hamilton County appropriations to the Primary Health System have been reduced from $3 million to $1.5 million for fiscal years 2014 and 2013.

Several initiatives continue to be underway to increase the Primary Health System's profitable position for the upcoming fiscal year. Operating improvements are being implemented to continue to reduce expenses and grow surgical volumes. Increased surgery volumes are essential to the financial health of the Primary Health System.

Audited Combined Financial Statements

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position - Continued

	June 30, 2014	
	Primary Health System	*Discretely Presented Component Units*
CURRENT ASSETS:		
Cash and cash equivalents	$ 44,202,064	$ 765,461
Temporary investments	1,384,865	5,564,277
Assets limited as to use available for current liabilities	7	-
Patient accounts receivable, net	79,428,961	1,950,888
Estimated amounts due from third party payers	11,408,963	-
Due from other governments	126,882	369,250
Inventories	11,612,639	1,133,754
Receivable from Hutcheson Medical Center	20,550,000	-
Other current assets	14,091,719	1,391,485
TOTAL CURRENT ASSETS	183,806,100	11,175,115
NET PROPERTY, PLANT AND EQUIPMENT	148,545,204	9,005,633
LONG-TERM INVESTMENTS, for working capital	326,139	-
ASSETS LIMITED AS TO USE	131,928,433	-
OTHER ASSETS:		
Prepaid bond insurance	2,093,412	-
Equity in discretely presented component units and other	14,124,270	-
Other assets	437,820	946,676
TOTAL OTHER ASSETS	16,655,502	946,676
TOTAL ASSETS	480,261,378	21,127,424
DEFERRED OUTFLOWS OF RESOURCES		
Deferred amounts from debt refunding	723,313	-
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 480,984,691	$ 21,127,424
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 41,948,260	$ 1,461,825
Accrued salaries and related liabilities	14,805,150	856,123
Estimated amounts due to third party payers	-	109,881
Due to other governments	369,250	126,882
Current portion of long-term debt and capital lease obligations	10,809,288	616,369
Other current liabilities	4,648,355	175,587
TOTAL CURRENT LIABILITIES	72,580,303	3,346,667
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	159,321,067	3,143,710
PENSION AND POST-EMPLOYMENT BENEFIT OBLIGATIONS	26,660,336	-
OTHER LONG-TERM LIABILITIES	23,913,836	-
TOTAL LIABILITIES	282,495,542	6,490,377
DEFERRED INFLOWS OF RESOURCES		
Deferred gain from sale-leaseback	3,935,725	-
NET POSITION:		
Unrestricted	190,840,242	9,316,184
Net investment in capital assets	1,234,111	5,320,863
Restricted expendable	2,479,071	-
TOTAL NET POSITION	194,553,424	14,637,047
LIABILITIES, DEFERRED OUTFLOWS OF RESOURCES AND NET POSITION	$ 480,984,691	$ 21,127,424

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position - Continued

	June 30, 2013 (Restated)	
	Primary Health System	*Discretely Presented Component Units*
CURRENT ASSETS:		
Cash and cash equivalents	$ 17,250,905	$ 930,587
Temporary investments	13,797,542	2,938,131
Assets limited as to use available for current liabilities	28,275	-
Patient accounts receivable, net	73,561,669	2,408,177
Estimated amounts due from third party payers	3,116,389	-
Due from other governments	528,032	377,239
Inventories	11,861,728	1,161,097
Receivable from Hutcheson Medical Center	20,550,000	-
Other current assets	20,129,320	1,917,719
TOTAL CURRENT ASSETS	160,823,860	9,732,950
NET PROPERTY, PLANT AND EQUIPMENT	160,973,575	9,643,816
LONG-TERM INVESTMENTS, for working capital	1,790,946	1,599,946
ASSETS LIMITED AS TO USE	130,231,028	-
OTHER ASSETS:		
Prepaid bond insurance	2,367,769	-
Equity in discretely presented component units and other	13,639,860	-
Other assets	437,820	858,972
TOTAL OTHER ASSETS	16,445,449	858,972
TOTAL ASSETS	470,264,858	21,835,684
DEFERRED OUTFLOWS OF RESOURCES		
Deferred amounts from debt refunding	809,251	-
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 471,074,109	$ 21,835,684
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 46,945,723	$ 1,425,315
Accrued salaries and related liabilities	14,015,721	910,318
Estimated amounts due to third party payers	-	93,625
Due to other governments	377,239	528,032
Current portion of long-term debt and capital lease obligations	8,058,625	556,698
Other current liabilities	2,194,117	838,223
TOTAL CURRENT LIABILITIES	71,591,425	4,352,211
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	170,179,424	3,445,959
PENSION AND POST-EMPLOYMENT BENEFIT OBLIGATIONS	17,406,052	-
OTHER LONG-TERM LIABILITIES	25,100,226	-
TOTAL LIABILITIES	284,277,127	7,798,170
DEFERRED INFLOWS OF RESOURCES		
Deferred gain from sale-leaseback	4,400,481	-
NET POSITION:		
Unrestricted	170,051,736	8,321,046
Net investment in capital assets	10,125,742	5,716,468
Restricted expendable	2,219,023	-
TOTAL NET POSITION	182,396,501	14,037,514
LIABILITIES, DEFERRED OUTFLOWS OF RESOURCES AND NET POSITION	$ 471,074,109	$ 21,835,684

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Revenue, Expenses and Changes in Net Position - Continued

	Year Ended June 30, 2014	
	Primary Health System	*Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 571,264,197	$ 11,231,722
Other revenue	20,718,399	17,098,407
TOTAL OPERATING REVENUE	591,982,596	28,330,129
OPERATING EXPENSES:		
Salaries, wages and benefits	305,113,185	13,638,588
Supplies and other expenses	122,623,180	10,246,727
Purchased services	117,156,784	2,573,864
Insurance and taxes	2,988,771	379,274
Depreciation	26,182,683	1,109,747
TOTAL OPERATING EXPENSES	574,064,603	27,948,200
OPERATING INCOME	17,917,993	381,929
NONOPERATING REVENUE (EXPENSES):		
Gain on disposal of assets	371,296	18,496
Interest and investment income, net of fees	245,537	397,461
Net gain from discretely presented component units and other	484,410	-
Interest expense	(8,559,590)	(181,803)
Provision for income taxes	-	(16,550)
Change in mark-to-market of interest rate swaps	873,783	-
NET NONOPERATING REVENUE (EXPENSES)	(6,584,564)	217,604
INCOME BEFORE CONTRIBUTIONS	11,333,429	599,533
Operating contributions	382,825	-
Capital contributions	440,669	-
CHANGE IN NET POSITION	12,156,923	599,533
NET POSITION AT BEGINNING OF YEAR	182,396,501	14,037,514
NET POSITION AT END OF YEAR	$ 194,553,424	$ 14,637,047

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Revenue, Expenses and Changes in Net Position - Continued

	Year Ended June 30, 2013 (Restated)	
	Primary Health System	*Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 526,139,300	$ 11,345,856
Other revenue	18,969,187	16,241,907
TOTAL OPERATING REVENUE	545,108,487	27,587,763
OPERATING EXPENSES:		
Salaries, wages and benefits	297,831,739	13,607,440
Supplies and other expenses	110,970,317	10,199,559
Purchased services	114,011,044	2,981,048
Insurance and taxes	2,476,434	295,336
Depreciation	26,856,073	1,045,235
TOTAL OPERATING EXPENSES	552,145,607	28,128,618
OPERATING LOSS	(7,037,120)	(540,855)
NONOPERATING REVENUE (EXPENSES):		
Gain on disposal of assets	244,660	590,326
Interest and investment income, net of fees	24,827	104,642
Net loss from discretely presented component units and other	(261,887)	(175,000)
Interest expense	(9,190,977)	(208,669)
Provision for income taxes	-	(8,663)
Change in mark-to-market of interest rate swaps	2,256,035	-
NET NONOPERATING REVENUE (EXPENSES)	(6,927,342)	302,636
LOSS BEFORE CONTRIBUTIONS	(13,964,462)	(238,219)
Operating distributions	7,248	-
Capital contributions/other, net	220,977	-
CHANGE IN NET POSITION	(13,736,237)	(238,219)
NET POSITION AT BEGINNING OF YEAR, as previously reported	199,949,930	14,275,733
CUMULATIVE EFFECT OF CHANGE IN ACCOUNTING PRINCIPLE	(3,817,192)	-
NET POSITION AT BEGINNING OF YEAR	196,132,738	14,275,733
NET POSITION AT END OF YEAR	$ 182,396,501	$ 14,037,514

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Cash Flows - Continued

	Primary Health System Year Ended June 30, 2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from third-party payers and patients	$ 561,765,342	$ 527,371,215
Payments to vendors and others for supplies, purchased services, and other expenses	(245,573,098)	(217,039,131)
Payments to and on behalf of employees	(295,049,472)	(297,118,972)
Other receipts	22,685,770	23,375,977
NET CASH PROVIDED BY OPERATING ACTIVITIES	43,828,542	36,589,089
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES:		
Contributions	382,825	7,248
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Acquisition and construction of capital assets, net	(13,929,432)	(30,339,955)
Principal paid on bonds, capital lease obligations and other	(8,048,272)	(7,900,842)
Proceeds from sale of assets	81,660	473,130
Interest payments on long-term debt	(8,258,717)	(8,971,728)
Capital contributions	440,669	220,977
NET CASH USED IN CAPITAL AND RELATED FINANCING ACTIVITIES	(29,714,092)	(46,518,418)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Interest, dividends, and net realized gains (losses) on investments	245,537	2,468,950
Change in temporary and long-term investments for working capital	13,877,484	(815,435)
Advances under note agreements	-	(8,050,000)
Net cash provided by (transferred to) assets limited as to use	(1,669,137)	5,749,002
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	12,453,884	(647,483)
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	26,951,159	(10,569,564)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	17,250,905	27,820,469
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 44,202,064	$ 17,250,905

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Cash Flows - Continued

	Primary Health System Year Ended June 30, 2014	2013
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH PROVIDED BY OPERATING ACTIVITIES:		
Operating income (loss)	$ 17,917,993	$ (7,037,120)
Adjustments to reconcile operating loss to net cash provided by operating activities:		
Depreciation	26,182,683	26,856,073
Amortization of other liabilities	(393,607)	(620,506)
Changes in assets and liabilities:		
Patient accounts receivable, net	(5,867,292)	3,079,769
Estimated amounts due from third party payers, net	(8,292,574)	(3,497,287)
Inventories and other assets	6,687,840	6,261,212
Accounts payable and accrued expenses	(4,916,463)	10,187,021
Accrued salaries and related liabilities	789,429	(135,013)
Other current and long-term liabilities	11,720,533	1,494,940
NET CASH PROVIDED BY OPERATING ACTIVITIES	$ 43,828,542	$ 36,589,089

SUPPLEMENTAL INFORMATION:

During the year ended June 30, 2013, The Primary Health System received a commitment from a third party to reimburse the Primary Health System for $1,900,000 in renovations performed at Erlanger East. The Primary Health System also recorded a liability in the amount of $1,900,000 that will be amortized (and recognized as operating revenue) over the lease term of 20 years.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements

Years Ended June 30, 2014 and 2013

NOTE A--SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity: The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Chattanooga-Hamilton County Hospital Authority consists of the Primary Health System and its aggregate discretely presented component units as disclosed below.

The Primary Health System provides comprehensive healthcare services throughout Hamilton and Bledsoe counties, as well as outlying areas in southeastern Tennessee and north Georgia. These services are provided primarily through the hospital and other facilities located on the Baroness campus of Erlanger Medical Center. The Primary Health System also operates other hospitals and clinics throughout the area. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by accounting principles generally accepted in the United States of America, these combined financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational or financial relationships with the Primary Health System.

The primary mission of the Primary Health System and its component units is to provide healthcare services to the citizens of Chattanooga, Hamilton County and the surrounding area. Only those activities directly associated with this purpose are considered to be operating activities. Other activities that result in gains or losses unrelated to the Primary Health System's primary mission are considered to be nonoperating.

Erlanger Health Plan Trust, Plaza Surgery, G.P., ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC, and UT-Erlanger Medical Group, Inc. are legally separate organizations which the Primary Health System has determined are component units of the Primary Health System.

Blended Component Units: The financial statements of Erlanger Health Plan Trust include assets limited as to use totaling $1,627,033 and $1,619,834 as of June 30, 2014 and 2013, respectively, and net investment income totaling $7,199 and $9,987 for the years ended June 30, 2014 and 2013, respectively, that are blended in the combined financial statements of the Primary Health System. The board of the Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

Plaza Surgery, G.P. (Plaza) was a joint venture which operated an ambulatory surgery center on the Primary Health System's campus. In 2012, the Primary Health System purchased all the remaining outstanding units of Plaza and its operations were transferred to the Primary Health

System, although Plaza remains a separate legal entity. Plaza had no assets, liabilities or operations in 2014 or 2013.

Discretely Presented Component Units: The discretely presented component units column in the combined financial statements includes the financial data of the Primary Health System's other component units. They are reported in a separate column to emphasize that they are legally separate from the Primary Health System. See the combined, condensed financial information in Note Q.

1. ContinuCare HealthServices, Inc. and subsidiary (ContinuCare) provide health and supportive services to individuals in their homes in the Hamilton County and north Georgia areas. ContinuCare also provides retail pharmacy goods and services at four locations in Hamilton County. The Primary Health System owns 100% of the stock of ContinuCare. Separately audited financial statements for ContinuCare HealthServices, Inc. may be obtained by mailing a request to 1501 Riverside Drive, Suite 140, Chattanooga, Tennessee 37406.

2. Cyberknife of Chattanooga, LLC (Cyberknife) provides radiation therapy services, specifically robotic stereotactic radiosurgical services, through the use of a cyberknife stereotactic radiosurgery system on the Primary Health System's campus. At June 30, 2014 and 2013 the Primary Health System owns 51% of Cyberknife's outstanding membership units and Cyberknife is fiscally dependent on the Primary Health System.

   A condition of admission as a Member of Cyberknife, is to deliver limited guaranties, guaranteeing prorata repayment of indebtedness of Cyberknife incurred to finance its equipment costs and its working capital needs. As of June 30, 2014 and 2013, total debt outstanding was $3,679,502 and $3,916,667, respectively, with payments due through 2016. Management believes that the Primary Health System will not be required to make any payments related to the guarantee of this indebtedness.

3. UT-Erlanger Medical Group, Inc. (the Medical Group) was formed on June 30, 2011 and will provide professional healthcare and related services to the public through employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Primary Health System is not entitled to any potential earnings of the Medical Group except for compensation for services rendered to the Medical group on its behalf. However, based upon the significance of the Medical Group's potential operation to the Primary Health System, management believes its exclusion would be misleading and as such, includes the Medical Group as a component unit. The Medical Group is currently not active.

Erlanger Health System Foundations (the Foundation): The Foundation assists the Primary Health System to promote and develop charitable and educational opportunities as they relate to healthcare services provided by the Primary Health System. The Primary Health System is not financially accountable for the Foundation and as a result the Foundation has not been included in the combined financial statements.

Contributions from the Foundation totaling approximately $1,170,000 and $920,000 for the years ended June 30, 2014 and 2013, respectively, were recognized as contribution revenue by the Primary Health System. The Primary Health System provided support to the Foundation of $730,000 in 2014 and $347,000 in 2013.

Use of Estimates: The preparation of the combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the combined financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise Fund Accounting: The Primary Health System and its blended component units utilize the enterprise fund method of accounting whereby revenue and expenses are recognized on the accrual basis using the economic resources measurement focus.

Recently Issued or Effective Accounting Pronouncements: In June 2011, the Governmental Accounting Standards Board (GASB) issued Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position.* This Statement amends the net asset reporting requirements of GASB Statement No. 34 and other pronouncements by incorporating deferred outflows and inflows of resources into the definitions of the required components of the residual measure and renaming that measure as net position, rather than net assets. The requirements of this Statement were adopted by the Primary Health System in fiscal year 2013 and the adoption did not have a material impact on the combined financial statements.

In March 2012, the GASB issued Statement No. 65, *Items Previously Reported as Assets and Liabilities.* Statement No. 65 establishes reporting standards that reclassify items previously reported as assets or liabilities as deferred inflows or outflows and was adopted by the Primary Health System in 2014. GASB Statement No. 65 further requires that costs associated with the issuance of long-term debt, other than insurance costs, be expensed in the period incurred, rather than deferred and amortized over the term of the related debt. As a result of the retroactive application of this guidance, certain amounts previously reported as of and for the year ended June 30, 2013, have been restated and a cumulative effect adjustment has been recorded to the net position as of June 30, 2012. The effect of this application on previously reported combined financial statement amounts for the Primary Health System reduced deferred financing cost

reported at June 30, 2013 by $3,466,006 and reduced interest expense for the year ended June 30, 2013 by $351,186.

Further, GASB 65 requires certain amounts previously reported as assets or liabilities be reclassified as deferred outflows or inflows. Such items include the unrecognized gain on a sale-leaseback transaction and losses on previously refunded debt. The 2013 combined financial statements have been reclassified to conform with these provisions of Statement No. 65.

In June 2012, the GASB issued Statement No. 68, *Accounting and Financial Reporting for Pensions*. Statement No. 68 provides guidance for improved accounting and financial reporting by state and local government entities related to pensions. It also replaces the requirements of GASB Statement No. 27 and Statement No. 50, as they relate to pensions that are provided through pension plans administered as trusts or equivalent arrangements that meet certain criteria. Additionally, the GASB issued Statement No. 71, *Pension Transition for Contributions Made Subsequent to the Management Date*, which is effective concurrent with Statement No. 68. Among other requirements, the Primary Health System will have to record a net pension liability that is based on fiduciary plan net position rather than on plan funding an provide explanatory disclosures in the notes to the financial statements. These Statements are required for fiscal years beginning after June 15, 2014 with early adoption encouraged. These Statements will be effective for the Primary Health System in 2015 and management and its actuaries are currently evaluating its impact on the combined financial statements.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at rates which reflect the amount expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by third-party payer programs under payment formulas in effect. Net patient revenue also includes an estimated provision for bad debts based upon management's evaluation of collectability based upon the age of the receivables and other criteria, such as payer classification and management's assumptions about conditions it expects to exist and courses of action it expects to take. The Primary Health System's policies do not require collateral or other security for accounts receivable, although the Primary Health System routinely accepts assignment or is otherwise entitled to receive patient benefits payable under health insurance programs, plans or policies. Supplemental payments from the State of Tennessee are recognized when determinable (see Note B).

Charity Care: The Primary Health System accepts patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain policies established by the County Auditor with regard to the Hamilton County indigent program or by the Primary Health System for other patients. Essentially, these policies define charity services as those services for which minimal payment is anticipated. In assessing a patient's inability to pay, the County and the Primary Health System utilize the generally recognized poverty income levels, but also include

certain cases where incurred charges are significant when compared to the income of the patient. These charges are not included in net patient service revenue.

Cash Equivalents: The Primary Health System considers all highly liquid investments with maturities of three months or less when purchased, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be cash equivalents.

Inventories: Inventories consist principally of medical and surgical supplies, general store supplies, and pharmacy items and are stated at lower of cost (first-in, first-out) or fair market value.

Investments: The Primary Health System's investments (including assets limited as to use) are reported at fair market value based on quoted market prices. Assets limited as to use include funds designated by the Board, funds held by trustees under trust indentures, and funds restricted by donors or grantors for specific purposes. The Primary Health System considers those investments with maturities of more than three months when purchased, maturing in more than one year and whose use is not limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be long-term investments. Investments, including assets limited as to use, consist of United States government, government agency and municipal bonds, corporate debt and other short-term investments.

Temporary Investments: The Primary Health System considers all highly liquid investments with maturities of more than three months when purchased and maturing in less than one year, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be temporary investments. Temporary investments consist primarily of United States government agency bonds, municipal bonds and commercial paper.

Derivative Instruments: The Primary Health System records all derivatives as assets or liabilities on the combined statements of net position at estimated fair value and includes credit value adjustments. The Primary Health System's derivative holdings consist of interest rate swap agreements. Since these derivatives have not been determined to be effective, the gain or loss resulting from changes in the fair value of the derivatives is recognized in the accompanying combined statements of revenue, expenses and changes in net position. The Primary Health System's objectives in using derivatives are to take advantage of the differences between taxable and tax-exempt debt, and manage exposure to interest rate risks associated with various debt instruments (see Note N).

Net Property, Plant and Equipment: Property, plant and equipment is recorded on the basis of cost. Donated assets are recorded at their fair market value at the date of donation. Leases that

are substantially installment purchases of property are recorded as assets and amortized over their estimated useful lives ranging from three to thirty years; related amortization is included in depreciation expense. Depreciation expense is computed over estimated service lives of the respective classes of assets using the straight-line method. The Primary Health System has established a capitalization threshold for property, plant and equipment of $2,500 except for computer equipment, which has a threshold of $1,000. Interest expense and interest income on borrowed funds related to construction projects are capitalized during the construction period, if material. Costs of maintenance and repairs are charged to expense as incurred.

The Primary Health System reviews the carrying value of capital assets if facts and circumstances indicate that recoverability may be impaired. A capital asset is considered impaired when its service utility has declined significantly and unexpectedly. The Primary Health System did not experience any prominent events or changes in circumstances affecting capital assets which would require determination as to whether impairment of a capital asset has occurred during the years ended June 30, 2014 and 2013.

Compensated Absences: The Primary Health System recognizes an expense and accrues a liability for employees' paid annual leave and short-term disability in the period in which the employees' right to such compensated absences are earned. Liabilities expected to be paid within one year are included as accrued salaries and related liabilities in the accompanying combined statements of net position.

Prepaid Bond Insurance: Deferred financing costs consist of insurance costs associated with bond issues and are being amortized, generally, over the terms of the respective debt issues by the effective interest method.

Income Taxes: The Primary Health System is exempt from income taxes under Section 501(a) as an organization described in Section 501(c)(3) of the Internal Revenue Code (IRC). In addition, it qualifies for exemption from federal income taxes pursuant to IRC Section 115 as an instrumentality of the State of Tennessee. Therefore, no provision for income taxes has been recognized in the accompanying combined financial statements for the Primary Health System. Certain tax returns that are required for the years ended June 30, 2010 through 2013 are subject to examination by taxing authorities.

As a for-profit entity, ContinuCare is subject to state and federal income taxes. ContinuCare HealthServices, Inc. and its subsidiary file consolidated federal income tax returns separately from the Primary Health System. At June 30, 2014 and 2013, ContinuCare had no significant uncertain tax positions. Tax returns for the years ended June 30, 2008 through 2013 are subject to examination by taxing authorities.

As a Limited Liability Corporation, Cyberknife, a discretely presented component unit, is subject to State of Tennessee income taxes. At June 30, 2014 and 2013, Cyberknife had no significant uncertain tax positions. Tax returns for the years ended June 30, 2010 through 2013 are subject to examination by taxing authorities.

Contributed Resources: Resources restricted by donors for specific operating purposes are held as restricted funds and are recognized as operating or capital contributions in the accompanying combined financial statements. When expended for the intended purpose, they are reported as operating distributions and are recognized as other operating revenue. Contributed resources consist of amounts restricted by donors for specific purposes. Fundraising expenses are netted against contributions recognized.

Net Position: The net position of the Primary Health System is classified into three components. *Net investment in capital assets* consists of capital and other assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. The *restricted expendable* net position consists of assets that must be used for a particular purpose that are either externally imposed by creditors, grantors, contributors or laws or regulations of other governments or imposed by law through constitutional provisions or enabling legislation. *The unrestricted net position* is remaining assets that do not meet the definition of *net investment in capital assets* or *restricted expendable.*

Fair Value of Financial Instruments: The carrying amounts reported in the combined statements of net position for cash, accounts receivable, investments, accounts payable and accrued expenses approximate fair value.

The carrying value of long-term debt and capital lease obligations (including the current portion) was $170,130,355 as of June 30, 2014 and $178,238,049 as of June 30, 2013. The estimated fair value of long-term debt and capital lease obligations (including current portion) was $175,879,323 and $186,227,537 as of June 30, 2014 and 2013, respectively. The fair value of long-term debt related to fixed interest long-term debt and capital lease obligations was estimated using discounted cash flows, based on the Primary Health System's incremental borrowing rates or from quotes obtained from investment advisors. The fair value of long-term debt related to variable rate debt approximates its carrying value.

Subsequent Events: The Primary Health System evaluated all events or transactions that occurred after June 30, 2014 through September 17, 2014 , the date the combined financial statements were available to be issued.

Reclassifications: In addition to the adoption of GASB Statement 65, discussed previously, certain reclassifications have been made to the 2013 combined financial statements to conform with the 2014 combined financial statement presentation.

NOTE B--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates by the Primary Health System to net patient service revenue as presented in the combined statements of revenue, expenses and changes in net position for the years ended June 30, 2014 and 2013 is as follows:

	Primary Health System	
	2014	*2013*
Inpatient service charges	$ 1,053,446,232	$ 986,725,639
Outpatient service charges	810,507,858	706,628,068
Gross patient service charges	1,863,954,090	1,693,353,707
Less: Contractual adjustments and other discounts	1,099,744,626	991,945,605
Charity care	109,777,939	101,729,252
Estimated provision for bad debts	83,167,328	73,539,550
	1,292,689,893	1,167,214,407
Net patient service revenue	$ 571,264,197	$ 526,139,300

Charity Care and Community Benefit: The Private Act of the State of Tennessee establishing the Primary Health System obligates the Primary Health System to make its facilities and patient care programs available to the indigent residents of Hamilton County to the extent of funds appropriated by Hamilton County and adjusted operating profits, as defined. The annual appropriation from Hamilton County totaled $1,500,000 for fiscal year 2014 and 2013. Total charity care charges for services provided to the certified indigent residents of Hamilton County (net of the appropriation) were approximately $19,336,000 and $23,757,000 for the years ended June 30, 2014 and 2013 for the Primary Health System.

In addition to charity care provided to specific patients within the hospital setting, the Primary Health System also provides unreimbursed services to the community which includes free and low cost health screenings. The Primary Health System also hosts health fairs and helps sponsor many other events that are free to the public and are spread throughout the year in various community locations.

The Primary Health System's Community Relations department, which conducts health, wellness, safety education classes and health screenings, includes Erlanger HealthLink Plus, a free adult membership program with over 15,000 members in the Chattanooga Statistical Metropolitan Service Area. The program provides over 16 classes and/or screenings and fitness opportunities per month that are free or at a low cost to members and to the community. These classes and screenings are held in two primary locations with additional classes at satellite locations in the region. As part of Community Relations, Safe & Sound, an injury prevention

service of Children's Hospital, offers free educational events regarding childhood injury prevention, including free car seat inspection and installation workshops. The Community Relations program utilizes the services of physicians, nurses, volunteers, educators, registered dietitians, social workers, secretaries and management personnel of the Primary Health System. The Primary Health System's consumer call center, Erlanger HealthLink (423-778-LINK) is a free call center staffed by RN's to answer health questions, offer free physician referrals and to register participants in the programs offered by Community Relations, Women's & Infant Services and other departments and divisions of the Primary Health System.

Uncompensated Care Costs: The following table summarizes the estimated total uncompensated care costs provided by Erlanger Medical Center as defined by the State of Tennessee for the years ended June 30, 2014 and 2013:

	2014	*2013*
Uncompensated cost of TennCare/Medicaid	$ 27,610,055	$ 28,228,719
Traditional charity uncompensated costs	33,421,647	33,423,115
Bad debt cost	25,128,811	23,429,117
Total estimated uncompensated care costs	$ 86,160,513	$ 85,080,951

The uncompensated cost of TennCare/Medicaid is estimated by taking the estimated cost of providing care to the TennCare/Medicaid patients less payments from the TennCare and Medicaid programs. The payments exclude revenues from essential access and other, one-time supplemental payments from TennCare of approximately $12,756,000 and $10,615,000 for the years ended June 30, 2014 and 2013, respectively, as such payments are not guaranteed for future periods.

Revenue from Significant Payers: Gross patient service charges related to the Medicare program accounted for approximately 32.7% and 29.6% of the Primary Health System's patient service charges for the years ended June 30, 2014 and 2013, respectively. Gross patient service charges related to the TennCare/Medicaid programs accounted for approximately 21.6% and 24.1% of the Primary Health System's patient service charges for the years ending June 30, 2014 and 2013, respectively. TennCare typically reimburses providers at an amount less than their cost of providing services to TennCare patients. At June 30, 2014 and 2013, the Primary Health System has a credit concentration related to the Medicare and TennCare programs.

During 2014 and 2013, the Primary Health System recognized revenue from these programs related to disproportionate share payments and trauma fund payments of approximately $926,000 and $9,622,000, respectively. Such amounts are subject to audit and future distributions under these programs are not guaranteed. Additionally, in 2014 the Primary Health System received a

net payment of $19,587,000 from the Public Hospital Supplemental Payment Pool. Such amounts are expected to be received as long as the current TennCare waiver is intact.

Laws and regulations governing the Medicare and TennCare/Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates, as they relate to revenue recognized from these programs, will change by a material amount in the near term. The estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined. Final determination of amounts earned under prospective payment and cost reimbursement activities is subject to review by appropriate governmental authorities or their agents. Management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under Medicare and Medicaid programs. The effect of prior year cost report settlements, or changes in estimates, increased net patient service revenue by approximately $2,310,000 in 2014 and by approximately $2,163,000 in 2013.

The Primary Health System has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates, per diems and discounts from established charges.

NOTE C--CASH AND CASH EQUIVALENTS

Cash and cash equivalents reported on the combined statements of net position include cash on hand and deposits with financial institutions including demand deposits and certificates of deposit.

The carrying amount of cash and cash equivalents consists of the following at June 30:

	Primary Health System	
	2014	*2013*
Demand deposits	$ 42,001,383	$ 15,087,535
Cash on hand	9,979	9,904
Cash equivalents	2,190,702	2,153,466
	$ 44,202,064	$ 17,250,905

Cash equivalents include money market accounts that are held in investment accounts and meet the definition of a cash equivalent.

Bank balances consist of the following at June 30:

	Primary Health System 2014	2013
Insured (FDIC)	$ 583,952	$ 622,493
Collateralized under the State of Tennessee Bank Collateral Pool	42,479,795	21,221,755
Other	-	272,275
	$ 43,063,747	$ 22,116,523

The Primary Health System's deposits would be exposed to custodial credit risk if they are not covered by depository insurance and the deposits are uncollateralized or are collateralized with securities held by the pledging financial institution's trust department or agent but not in the depositor government's name. The risk is that, in the event of the failure of a depository financial institution, the Primary Health System will not be able to recover deposits or will not be able to recover collateral securities that are in the possession of an outside party.

NOTE D--DISAGGREGATION OF RECEIVABLE AND PAYABLE BALANCES

Patient Accounts Receivable, Net: Patient accounts receivable and related allowances are as follows at June 30:

	Primary Health System 2014	2013
Gross patient accounts receivable	$ 302,865,848	$ 270,824,481
Estimated allowances for contractual adjustments and uncollectible accounts	(223,436,887)	(197,262,812)
Net patient accounts receivable	$ 79,428,961	$ 73,561,669

Other Current Assets: Other current assets consist of the following at June 30:

	Primary Health System 2014	2013
Prepaid expenses	$ 5,662,522	$ 5,205,938
Other receivables	8,429,197	14,923,382
Total other current assets	$ 14,091,719	$ 20,129,320

Accounts Payable and Accrued Expenses: Accounts payable and accrued expenses consist of the following at June 30:

	Primary Health System	
	2014	*2013*
Due to vendors	$ 39,008,464	$ 44,847,075
Other	2,939,796	2,098,648
Total accounts payable and accrued expenses	$ 41,948,260	$ 46,945,723

Other Long-Term Liabilities: Other long-term liabilities, and the related activity, consist of the following at June 30:

	Balance at Beginning of Year	*Unearned Revenue*	*Unearned Revenue Recognized*	*Change in Estimate*	*Other*	*Balance at End of Year*
2014						
Compensated absences	$ 10,638,408	$ -	$ -	$ -	$ -	$ 10,638,408
Medical malpractice	4,985,000	-	-	81,000	-	5,066,000
Job injury program	1,253,139	-	-	-	-	1,253,139
Interest rate swaps	4,856,429	-	-	-	(873,783)	3,982,646
Other	3,367,250	-	(393,607)	-	-	2,973,643
Total other long-term liabilities	$ 25,100,226	$ -	$ (393,607)	$ 81,000	$ (873,783)	$ 23,913,836
2013						
Compensated absences	$ 10,638,408	$ -	$ -	$ -	$ -	$ 10,638,408
Medical malpractice	5,462,500	-	-	(477,500)	-	4,985,000
Job injury program	916,104	-	-	337,035	-	1,253,139
Interest rate swaps	7,112,464	-	-	-	(2,256,035)	4,856,429
Other	623,000	2,900,000	(155,750)	-	-	3,367,250
Total other long-term liabilities	$ 24,752,476	$ 2,900,000	$ (155,750)	$ (140,465)	$ (2,256,035)	$ 25,100,226

NOTE E--NET PROPERTY, PLANT AND EQUIPMENT

Net property, plant and equipment activity for the Primary Health System for the years ended June 30, 2014 and 2013 consisted of the following:

	Balance at June 30, 2012	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2013*	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2014*
Capital assets:							
Land and improvements	$ 25,355,906	$ 298,962	$ -	$ 25,654,868	$ 312,049	$ -	$ 25,966,917
Buildings	223,875,935	6,845,858	-	230,721,793	2,900,701	-	233,622,494
Equipment	350,516,661	20,581,177	(4,240,082)	366,857,756	14,813,614	(4,980,876)	376,690,494
	599,748,502	27,725,997	(4,240,082)	623,234,417	18,026,364	(4,980,876)	636,279,905

	Balance at June 30, 2012	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2013*	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2014*
Accumulated depreciation :							
Land and improvements	(11,225,230)	(398,356)	-	(11,623,586)	(449,132)	-	(12,072,718)
Buildings	(161,792,780)	(7,808,629)	319,543	(169,281,866)	(6,812,804)	-	(176,094,670)
Equipment	(275,787,226)	(18,649,088)	3,692,069	(290,744,245)	(18,920,746)	4,805,755	(304,859,236)
	(448,805,236)	(26,856,073)	4,011,612	(471,649,697)	(26,182,682)	4,805,755	(493,026,624)
Capital assets net of accumulated depreciation	150,943,266	869,924	(228,470)	151,584,720	(8,156,318)	(175,121)	143,253,281
Construction in progress	6,774,897	24,935,626	(22,321,668)	9,388,855	10,852,113	(14,949,045)	5,291,923
	$ 157,718,163	$ 25,805,550	$ (22,550,138)	$ 160,973,575	$ 2,695,795	$ (15,124,166)	$ 148,545,204

Depreciation expense totaled $26,182,683 and $26,856,073 for the years ended June 30, 2014 and 2013, respectively. Construction in progress at June 30, 2014 consists of various projects for additions and renovations to the Primary Health System's facilities. The estimated cost to complete construction projects is approximately $10,320,000.

During 2012, the Primary Health System entered into an agreement to sell certain professional office buildings (POBs) and concurrently entered into agreements to lease space from the purchaser. The sales price of the POBs was approximately $13,333,000, and a gain of approximately $6,695,000 was realized. Since the Primary Health System is leasing back certain space, a portion of the gain has been deferred and is being recognized over the terms of the leases. Amortization of the deferred gain is included in non-operating revenue (expenses) for the years ended June 30, 2014 and 2013.

The leases entered into (or committed to) under this sale/leaseback agreement include certain leases which meet the criteria for capitalization and are included in Note M.

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE

The Primary Health System invests in United States government and agency bonds, municipal bonds, corporate debt, certificates of deposit and short-term money market investments that are in accordance with the Primary Health System's investment policy. Temporary investments at June 30, 2014 consist primarily of cash equivalents, government bonds and commercial paper.

The carrying and estimated fair values for long-term investments, and assets limited as to use, by type, at June 30 are as follows:

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

	Primary Health System 2014	2013
U.S. Government and agency bonds, including municipal bonds, mutual funds, and other	$ 108,694,164	$ 111,569,814
Corporate bonds and commercial paper	7,004,219	4,348,798
Short-term investments and cash equivalents	16,556,196	16,131,637
Total investments and assets limited as to use	$ 132,254,579	$ 132,050,249

Assets limited as to use are classified as follows:

	Primary Health System 2014	2013
Capital investment funds	$ 101,463,961	$ 99,572,404
Under bond indentures - held by trustees	20,879,910	20,901,235
Self-insurance trust	6,098,629	6,318,010
Restricted by donors and other	3,485,940	3,467,654
	131,928,440	130,259,303
Less current portion	(7)	(28,275)
Total assets whose use is limited	$ 131,928,433	$ 130,231,028

Assets limited as to use for capital improvements are to be used for the replacement of property and equipment or for any other purposes so designated.

Funds held by trustees under bond indenture at June 30 are as follows:

	Primary Health System 2014	2013
Debt service reserve funds	$ 20,725,843	$ 20,718,915
Principal and interest funds	7	28,275
Other funds	154,060	154,045
Total funds held by trustees under bond indenture	$ 20,879,910	$ 20,901,235

These funds held by trustees consist primarily of United States government agency obligations, state and local government obligations, corporate debt, and other short-term investments and cash equivalents. The debt service reserve fund is to be used only to make up any deficiencies in other funds related to the Hospital Revenue and Refunding Bonds Series 1997A, Series 1998A, Series 2000 and Series 2004. The principal and interest funds are to be used only to pay

principal and interest, respectively, on the Series 1997A, Series 1998A, Series 2000 and Series 2004 bonds.

The Primary Health System's investment policy specifies the types of investments which can be included in board-designated assets limited as to use, as well as collateral or other security requirements. The investment policy also specifies the maximum maturity of the portfolio of board-designated assets. Assets limited as to use and held by trustees are invested as permitted by the bond indenture.

Custodial Credit Risk: The Primary Health System's investment securities are exposed to custodial credit risk if the securities are uninsured, are not registered in the name of the Primary Health System, and are held by either the counterparty or the counterparty's trust department or agent but not in the Primary Health System's name. The risk is that, in the event of the failure of the counterparty to a transaction, the Primary Health System will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party.

As of June 30, 2014 and 2013, the Primary Health System's investments, including assets limited as to use, were comprised of various short-term investments, U.S. government and government agency bonds, municipal obligations, corporate bonds, commercial paper, and other U.S. Treasury obligations. Substantially all of the Primary Health System's investments, including assets limited as to use, are uninsured or unregistered. Securities are held by the counterparty, or by its trust department or agent, in the Primary Health System's name.

Concentration of Credit Risk: This is the risk associated with the amount of investments the Primary Health System has with any one issuer that exceeds 5% or more of its total investments. Investments issued or explicitly guaranteed by the U.S. Government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement. The Primary Health System's investment policy does not restrict the amount that may be held for any single issuer. At June 30, 2014, none of the Primary Health System's investments with any one issuer exceed 5% of its total investments except certain U.S. Government agencies.

Credit Risk: This is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. GASB No. 40 requires that disclosure be made as to the credit rating of all debt security investments except for obligations of the U.S. Government or obligations explicitly guaranteed by the U.S. Government. The Primary Health System's investment policy provides guidelines for its fund managers and lists specific allowable investments.

The credit risk profile of the Primary Health System's investments, including assets limited as to use (excluding U.S. Government securities), as of June 30, 2014, is as follows:

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

Investment Type	Balance as of June 30, 2014	Rating AAA	AA	A	BBB	N/A
U.S Government agency bonds	$ 46,375,721	$ 44,799,453	$ 1,576,268	$ -	$ -	$ -
Municipal bonds	7,226,430	2,259,170	3,958,340	1,008,920	-	-
Bond mutual funds and other	5,575,435	5,575,435	-	-	-	-
Corporate bonds and commercial paper	1,428,784	-	-	1,428,784	-	-
Cash equivalents	16,556,196	-	-	-	-	16,556,196
Total investments	$ 77,162,566	$ 52,634,058	$ 5,534,608	$ 2,437,704	$ -	$ 16,556,196

Investment Rate Risk: This is the risk that changes in interest rates will adversely affect the fair value of an investment. The Primary Health System's investment policy authorizes a strategic asset allocation that is designed to provide an optimal return over the Primary Health System's investment horizon and within specified risk tolerance and cash requirements.

The distribution of the Primary Health System's investments, including assets limited as to use, and excluding the self-insurance trust, by maturity as of June 30, 2014, is as follows:

Investment Type	Balance as of June 30, 2014	Remaining Maturity 12 months or less	13-24 Months	25-60 Months	Over 60 Months	N/A
U.S. Government bonds and agency funds	$ 101,467,734	$ 15,624,278	$ 34,072,420	$ 14,086,664	$ 37,684,372	$ -
Municipal bonds	7,226,430	3,032,240	3,192,400	1,001,790	-	-
Corporate bonds and commercial paper	1,428,784	1,428,784	-	-	-	-
Cash equivalents	16,033,002	16,033,002	-	-	-	-
Total investments	$ 126,155,950	$ 36,118,304	$ 37,264,820	$ 15,088,454	$ 37,684,372	$ -

Additionally, the distribution of the Primary Health System's investments held under the self-insurance trust as of June 30, 2014, is as follows:

Investment Type	Balance as of June 30, 2014	Remaining Maturity 24 months or less	25-60 Months	61-120 Months	Over 120 Months	N/A
Bond Mutual Funds	$ 5,575,435	$ -	$ -	$ -	$ -	$ 5,575,435
Cash equivalents	523,194	523,194	-	-	-	-
Total investments	$ 6,098,629	$ 523,194	$ -	$ -	$ -	$ 5,575,435

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

NOTE G--LONG-TERM DEBT

Long-term debt at June 30 consists of the following:

	Primary Health System	
	2014	*2013*
Revenue and Refunding Bonds, Series 2004, net of bond discount of $443,199 in 2014 and $532,793 in 2013 and including bond issue premium of $1,302,656 in 2014 and $1,443,483 in 2013	$ 66,859,457	$ 71,955,690
Hospital Revenue Refunding Bonds, Series 2000, including bond issue premium of $258,296 in 2014 and $281,255 in 2013	32,558,296	34,581,255
Hospital Revenue Bonds, Series 1998A, net of bond discount of $265,846 in 2014 and $280,615 in 2013	18,159,154	18,329,385
Hospital Revenue Bonds, Taxable Series 1997A	41,000,000	41,000,000
Total bonds payable	158,576,907	165,866,330
Other Loans and Notes Payable	4,978,158	5,630,515
Capital leases - Note M	6,575,290	6,741,204
	170,130,355	178,238,049
Less: current portion	(10,809,288)	(8,058,625)
	$ 159,321,067	$ 170,179,424

During fiscal year 2011, the Primary Health System entered into a term loan (the Loan) with a financial institution in the maximum amount of $7,000,000 to finance the acquisition of the Lifestyle Center property. The rate of interest on the loan is a fixed rate equal to 5.45%. Monthly payments of principal and interest are payable on the first day of each month for a 10 year term beginning December 1, 2010, with a final payment equal to the unpaid principal plus accrued and unpaid interest due at maturity. The loan contains certain covenants and restrictions. Management believes the Primary Health System was in compliance with all such covenants at June 30, 2014.

During fiscal year 2010, the Primary Health System remarketed the Series 2004 Hospital Revenue Refunding Bonds (Series 2004) and the Series 2000 Hospital Revenue Refunding Bonds (Series 2000), as described below, and converted such bonds from a variable auction rate to a fixed rate.

On January 1, 2004, the Primary Health System issued $85,000,000 insured Series 2004 bonds for the purpose of refunding $80,925,000 of the total outstanding Series 1993 bonds (described

below). The Primary Health System also utilized the proceeds to pay certain issuance costs and contributed a portion of the bond proceeds in the amount of $1,633,658 to establish a debt service fund.

The Series 2004 bonds were issued on parity, with respect to collateral, with other outstanding bonds, described below. The Series 2004 bonds are also secured by a mortgage on a portion of the Primary Health System's main campus. The Series 2004 bonds mature annually on October 1 beginning in 2010 through 2023 in varying amounts. The Series 2004 bonds maturing after October 1, 2019 (excluding those maturing on October 1, 2023) may be redeemed by the Primary Health System after October 1, 2019 at a redemption price equal to the principal amount plus accrued interest. The bonds maturing on October 1, 2023 may be redeemed prior to maturity pursuant to the extraordinary optional redemption and redemption upon damage or condemnation provisions as described in the Remarketing Memorandum by the Primary Health System after October 1, 2014 at a redemption price equal to 100% of the principal amount plus accrued interest. Interest rates for the outstanding Series 2004 bonds range from 3.0% to 5.0%.

In August 2000, the Primary Health System issued $47,300,000 insured Series 2000 bonds for the purpose of refunding $40,000,000 of then outstanding Series 1987 bonds and funding a debt service reserve fund in an original amount of $4,407,377 and to pay issuance costs. The Series 2000 bonds were issued on parity with other outstanding bond issues. The Series 2000 bonds consist of term bonds maturing on October 1, 2023 and serial bonds maturing on October 1 annually beginning in 2010 through 2025. The bonds maturing on October 1, 2023 are subject to mandatory sinking fund redemption prior to maturity and without premium at the principal amount thereof on October 1. The Series 2000 bonds maturing after October 1, 2014 may be redeemed by the Primary Health System after October 1, 2014 at a redemption price equal to the principal amount plus accrued interest.

Interest rates for the Series 2000 outstanding bonds are as follows:

Series Bonds	- 3.75% to 5.0%
Term Bonds	- 5.0%

The Primary Health System's 1997A and 1998A Hospital Revenue Bonds (Series 1997A and Series 1998A, respectively) were issued to fund capital improvements for Erlanger Medical Center and establish a debt service reserve fund (1998A only) in an original amount of $2,174,125.

The Series 1997A bonds are taxable and are secured on a parity under a Master Trust Indenture with other outstanding bond issues. The 1997A bonds mature beginning in fiscal year 2015 through fiscal year 2028. The 1997A bonds are subject to optional redemption at 100% plus

accrued interest and interest is payable at a variable auction rate for a 35-day period, which was 0.42% at June 30, 2014 and 0.49% at June 30, 2013.

The Series 1998A insured bonds are tax-exempt and consisted of $6,080,000 serial bonds maturing annually on October 1 of each year through 2013 in varying amounts; and term bonds maturing on October 1, 2018 and 2028 ($5,825,000 and $17,095,000, respectively). Such bonds are secured on parity with other outstanding bonds. The bonds maturing after October 1, 2008 may be redeemed by the Primary Health System after April 1, 2008 at amounts ranging from 100% to 101% of par value plus accrued interest.

Interest rates for the outstanding Series 1998A bonds are as follows:

$ 6,080,000 Serial Bonds	- 4.75% to 5.00%
$ 5,825,000 Term Bonds	- 5.0%
$17,095,000 Term Bonds	- 5.0%

During fiscal year 2002, the Primary Health System defeased $5,320,000 of the 1998A bond issuance because IRS regulations do not permit tax-exempt debenture proceeds to be used to fund for-profit endeavors. These funds were used in the construction of an Ambulatory Surgery Center. The Primary Health System contributed to an escrow account funds generated from its operations sufficient to fund all principal and interest payments for approximately $5,320,000 of debentures until maturity. The Primary Health System was released from being the primary obligor and cannot be held liable for the defeased obligation, of which approximately $4,140,000 remains outstanding at June 30, 2014.

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. As of June 30, 2014, management believes the Primary Health System is in compliance with all such covenants.

The Primary Health System's scheduled principal and interest payments (estimated for variable rate debt based on rates at June 30, 2014) on bonds payable and other long-term debt (excluding capital leases) are as follows for the years ending June 30:

	Principal	*Interest*	*Total*
2015	$ 10,613,005	$ 5,868,787	$ 16,481,792
2016	11,637,069	5,391,616	17,028,685
2017	11,723,446	4,945,072	16,668,518
2018	12,674,484	4,515,962	17,190,446
2019	13,242,765	4,001,214	17,243,979
2020-2024	71,002,389	12,068,476	83,070,865
2025-2029	31,810,000	1,748,790	33,558,790
TOTAL	$ 162,703,158	$ 38,539,917	$ 201,243,075

Long-term debt activity for the Primary Health System for the years ended June 30, 2014 and 2013 consisted of the following:

	Balance at June 30, 2012	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2013*	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2014*
Bonds Payable							
Series 2004	$ 76,754,321	$ 152,197	$ 4,950,828	$ 71,955,690	$ 89,594	$ 5,185,827	$ 66,859,457
Series 2000	36,404,215	-	1,822,960	34,581,255	-	2,022,959	32,558,296
Series 1998A	18,859,616	14,769	545,000	18,329,385	14,769	185,000	18,159,154
Series 1997A	41,000,000	-	-	41,000,000	-	-	41,000,000
Total bonds payable	173,018,152	166,966	7,318,788	165,866,330	104,363	7,393,786	158,576,907
Term Loan	6,282,894	-	652,379	5,630,515	-	652,357	4,978,158
Capital leases	6,834,667	-	93,463	6,741,204	-	165,914	6,575,290
Total long-term debt	$ 186,135,713	$ 166,966	$ 8,064,630	$ 178,238,049	$ 104,363	$ 8,212,057	$ 170,130,355

NOTE H--PENSION PLAN

The Primary Health System sponsors a single-employer, non-contributory defined benefit pension plan covering substantially all employees meeting certain age and service requirements. In addition to normal retirement benefits, the plan also provides for early retirement, delayed retirement, disability and death benefits. The Primary Health System funds the plan as contributions are approved by the Board of Trustees. The Primary Health System has the right to amend, in whole or in part, any or all of the provisions of the plan. Effective July 1, 2009, the plan was amended to be closed to new employees or rehires, and to further clarify the maximum years of service to be 30. During June 2014, the plan was amended to freeze the accrual of additional benefits going forward. The actuarial computations below do not include the impact of this amendment.

The plan issues a publicly available financial report that includes a financial statement and required supplementary information for the plan. That report may be obtained by writing to

Erlanger Health System, Attention: Human Resources Department, 975 East Third Street, Chattanooga, Tennessee 37403 or by calling 423-778-7000.

The annual pension cost and net pension obligation for the years ended June 30, 2014 and 2013 are as follows:

	Primary Health System	
	2014	*2013*
Annual required contribution	$ 12,832,292	$ 11,165,100
Interest on net pension obligation	782,963	791,073
Adjustment to annual required contribution	(1,024,034)	(899,189)
Annual pension cost	12,591,221	11,056,984
Contributions made	-	(11,165,100)
Change in net pension obligation	12,591,221	(108,116)
Net pension obligation at beginning of year	10,439,507	10,547,623
Net pension obligation at end of year	$ 23,030,728	$ 10,439,507

The annual expected contribution for the years ended June 30, 2014 and 2013, was determined as part of the January 1, 2014 and 2013 actuarial valuations, respectively, using the projected unit credit cost method. The following actuarial assumptions were utilized:

	2014	*2013*
Investment rate of return	7.5%	7.5%
Projected salary increases	4.0%	4.0%
Inflation	2.5%	2.5%
Increase in Social Security taxable wage base	3.5%	3.5%

Annual pension costs, contribution information and the net pension obligation for the last three fiscal years follows:

	Three-Year Trend Information		
Fiscal Year Ending	*Annual Pension Cost (APC)*	*Percentage of APC Contributed*	*Net Pension Obligation*
June 30, 2012	$ 10,264,968	101%	$ 10,547,623
June 30, 2013	11,056,984	101%	10,439,507
June 30, 2014	12,591,221	0%	23,030,728

The schedule of funding progress shown below presents multi-year trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liability for benefits. The actuarial asset values are determined using prior year valuations with the addition of current year contributions and expected investment return on market value of assets based on an assumed rate of 7.5%, and deducting benefit payments and administrative expenses for the year. The actuarial value of assets was determined using techniques that smooth the effects of short-term volatility in the market value of investments using an average of cost and market value. The plan will reset the amortization base each year equal to the unfunded actuarial accrued liability to be amortized over a closed 20 year period and using a level dollar amount as the amortization factor.

Schedule of Funding Progress

Actuarial Valuation Date	*Actuarial Value of Assets*	*Actuarial Accrued Liability (AAL)*	*Total Unfunded AAL (UAAL)*	*Funded Ratio %*	*Annual Covered Payroll*	*UAAL as a Percentage of Covered Payroll*
1/1/11	$125,335,932	$ 150,926,741	$25,590,809	83.0%	$ 147,947,134	17.3%
1/1/12	124,520,999	160,704,688	36,183,689	77.5%	138,807,819	26.1%
1/1/13	121,700,323	170,980,311	49,279,988	71.2%	121,093,695	40.7%

NOTE I--OTHER RETIREMENT PLANS

The Primary Health System maintains defined contribution plans under Section 403(b) and 401(a) of the IRC which provides for voluntary contributions by employees. The Plans are for the benefit of all employees 25 years of age or older with at least 12 months of employment.

The Primary Health System matches 50% of each participant's contribution up to 2% of the participant's earnings. Additionally, for eligible employees hired on after July 1, 2009 the Primary Health System will make profit sharing contributions equal to 3% of their earnings, regardless if the employee is making contributions. Employer contributions to the plan were approximately $1,770,000 and $1,830,000 for the years ended June 30, 2014 and 2013, respectively.

NOTE J--POST-EMPLOYMENT BENEFITS OTHER THAN PENSIONS

The Primary Health System sponsors three post-employment benefit plans other than pensions (OPEB) for full-time employees who have reached retirement age, as defined. The respective plans provide medical, dental, prescription drug and life insurance benefits, along with a limited lump-sum cash payment for a percent of the hours in the participant's short-term disability at retirement. The postretirement health, dental and prescription drug plan is contributory and

contains other cost-sharing features, such as deductibles and coinsurance. The life insurance plan and the short-term disability are noncontributory.

During 2014, the postretirement health, dental and prescription drug plan was amended to increase the amount of required participant contributions. Additionally, eligibility for the short-term disability was limited to employees that had attained age 55 and completed 10 years of service as of January 1, 2014 or attained age 65 with at least 5 years of service as of this date. The lump-sum payout for the short-term disability was also reduced from 50% to 20% of the amount accumulated.

Beginning in 2018, under the Patient Protection and Affordable Care Act (the Act), a 40% excise tax will be imposed on the excess benefit provided to an employee or retiree in any month under any employer-sponsored health plan. In the case of a self-insured plan, the plan administrator must pay the tax. Because of the significant uncertainties regarding the excise tax on high cost plans, management of the Primary Health System is evaluating the impact of this Act but does not anticipate a material impact on the accrued liability at this time; however, actual results could differ from these estimates.

The following table shows the plans, funded status as of June 30:

	2014	*2013*
Actuarial accrued liability	$ 16,773,895	$ 30,500,450
Market value of assets	-	-
Unfunded actuarial accrued liability	$ 16,773,895	$ 30,500,450

The following is a summary of the components of the annual OPEB cost recognized by the Primary Health System for the years ended June 30:

	2014	*2013*
Annual required contribution	$ 2,032,983	$ 2,945,355
Interest on the net obligation	153,565	228,288
Adjustment for plan amendment	(3,127,421)	-
Amortization of net obligation	(152,570)	(226,809)
OPEB cost (benefit) recognized	$ (1,093,443)	$ 2,946,834

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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

A reconciliation of the net OPEB obligation for the fiscal years ended June 30 is as follows:

	2014	2013
Net OPEB obligation beginning of the year	$ 6,966,545	$ 5,707,193
OPEB cost (benefit) recognized	(1,093,443)	2,946,834
Actual contributions	(2,223,494)	(1,687,482)
Net OPEB obligation end of the year	$ 3,649,608	$ 6,966,545

Trend Information

Fiscal Year Ending	Annual OPEB Cost (Benefit)	Percentage of Annual OPEB Cost Contributed	Net OPEB Obligation at the End of Year
July 1, 2012	$ 2,666,393	39.6%	$ 5,707,193
July 1, 2013	2,946,834	57.3%	6,966,545
July 1, 2014	(1,093,443)	N/A	3,649,608

Schedule of Funding Progress

Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability	Unfunded Actuarial Accrued Liability	Annual Covered Payroll	Unfunded Actuarial Accrued Liability as a Percent of Covered Payroll	Funded Ratio
July 1, 2012	$ -	$ 28,788,147	$ 28,788,147	$138,807,819	20.7%	0%
July 1, 2013	-	30,500,450	30,500,450	155,727,806	19.6%	0%
July 1, 2014	-	16,773,895	16,773,895	167,104,474	10.0%	0%

The actuarial calculations reflect a long-term perspective. Accordingly, the actuarial valuation involves estimates of the value of reported amounts and assumptions about the probability of events far into the future, and actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

The schedule of funding progress presents multi-year trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liability. The calculations are based on the benefits currently provided under the terms of the plan as of the date of each valuation and on the sharing of cost between employer and plan members at that point.

The actuarial cost method utilized is the unit credit actuarial cost method. The 2014 and 2013 postretirement benefit cost assumed an average weighted annual rate increase in per capita cost of covered health benefits of 7.4%, decreasing gradually to an ultimate rate of 4.8%.

The amortization method used is the level percent of payroll method over a thirty-year amortization. Other assumptions include a 4% discount rate and assumed salary increases of 4.0% annually until age 65.

The Primary Health System also has a job injury program to provide benefits to workers injured in employment-related accidents. This program provides medical and indemnity benefits to employees injured in the course of employment for a period up to 24 months from the date of injury. The Primary Health System has recorded a projected liability that is included in other long-term liabilities in the combined statements of net position. The projected liability was discounted using a 4% rate of return at June 30, 2014 and 2013.

NOTE K--MEDICAL MALPRACTICE AND GENERAL LIABILITY CLAIMS

As of January 1, 1976, the Primary Health System adopted a self-insurance plan to provide for malpractice and general liability claims and expenses arising from services rendered subsequent to that date. In 1980, the Primary Health System's Self-Insurance Trust Agreement (the Agreement) was amended to include all coverages that a general public liability insurance policy would cover. In 1988, the Agreement was amended and restated to comply with amendments to the Tennessee Governmental Tort Liability Act and to formally include any claims and expenses related to acts of employees of the Primary Health System. The Primary Health System is funding actuarial estimated liabilities through a revocable trust fund with a bank. The trust assets are included as a part of assets limited as to use in the accompanying combined statements of net position. Such amounts in the trust can be withdrawn by the Primary Health System only to the extent there is an actuarially determined excess. The annual deposit to the self-insurance trust fund is determined by management based on known and threatened claims, consultation with legal counsel, and a report of an independent actuary. Losses against the Primary Health System are generally limited by the Tennessee Governmental Tort Liability Act to $300,000 for injury or death to any one person in any one occurrence or $700,000 in the aggregate. However, claims against healthcare practitioners are not subject to the foregoing limits applicable to the Primary Health System. Any such individuals employed by the Primary Health System, excluding employed physicians for which the Primary Health System has purchased insurance coverage, are covered by the Trust to the limits set forth therein.

In the opinion of management, the revocable trust fund assets are adequate at June 30, 2014, to cover potential liability and malpractice claims and expenses that may have been incurred to that date.

The Primary Health System provides for claims and expenses in the period in which the incidence related to such claims occur based on historical experience and consultation with legal counsel. It is the opinion of management that the reserve for estimated losses and loss adjustment expense (LAE) at June 30, 2014 is adequate to cover potential liability and

malpractice claims which may have been incurred but not reported (IBNR) to the Primary Health System. Such reserve for IBNR claims reflects a discount rate of 5.5% based on the Primary Health System's expected investment return during the payout period.

NOTE L--COMMITMENTS AND CONTINGENCIES

Litigation: The Primary Health System is subject to claims and suits which arise in the ordinary course of business. In the opinion of management, the ultimate resolution of such pending legal proceedings has been adequately provided for in its combined financial statements, and will not have a material effect on the Primary Health System's results of operations or financial position.

The prior Chief Executive Officer (CEO) resigned from Erlanger on December 31, 2011, after an interim CEO (the Executive Vice President) was established December 1, 2011. The interim CEO was replaced by the current CEO, hired on April 1, 2013. The Executive Vice President's employment at Erlanger ended when her leave expired in June, 2013. She has filed a wrongful termination lawsuit against Erlanger for $25 million, which Erlanger, in conjunction with its Directors and Officers insurance carrier, is currently defending. The ultimate outcome of this lawsuit is uncertain.

Regulatory Compliance: The healthcare industry is subject to numerous law and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, Medicare fraud and abuse, and most recently under the Provision of Health Insurance Portability and Accountability Act of 1996, matters related to patient records, privacy and security. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers, such as the Medicare Recovery Audit Contractor Program. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or un-asserted at this time.

In the normal course of business, the Primary Health System continuously monitors and investigates potential issues through its compliance program. Currently several investigations related to potential non-compliance are underway and the Primary Health System recognizes a liability when it is determined to exist and the amount can be reasonably estimated. Management currently believes that the Primary Health System is in compliance with applicable laws and regulations or has reported any amounts payable related known violations, including amounts identified through the Medicare Recovery Audit Contractor program, or similar initiatives, and any settlements will not have a significant impact on the combined financial

statements. However, due to the uncertainties involved and the status of ongoing investigations, management's estimate could change in the near future and the amount of the change could be significant.

Health Care Reform: In March 2010, Congress adopted comprehensive healthcare insurance legislation, Patient Care Protection and Affordable Care Act and Health Care and Education Reconciliation Act. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE M--LEASES

Capital: As discussed in Note E, during 2012, the Primary Health System entered into a sale/leaseback arrangement, under which certain leases of office space meet the criteria as capital leases. Interest on these leases has been estimated at 7% per annum.

During 2011, the Primary Health System acquired a parcel of land from the Industrial Development Board of the City of Chattanooga, Tennessee for a nominal amount. The Primary Health System also entered into a project development agreement with a developer to facilitate final design, financing and construction of a medical office building for the benefit of Volkswagen Group of America Chattanooga Operations, LLC (Volkswagen) on this land. The Primary Health System has entered into a forty-year ground lease, with the option of two ten-year renewal terms, of the parcel to the developer. Additionally, in 2012, the Primary Health System has entered into a twenty year lease with the developer for certain space in the medical office building for a wellness center and other operations under a capital lease agreement.

The following is an analysis of the property under capital leases by major classes at June 30:

	Primary Health System	
	2014	*2013*
Buildings	$ 6,601,812	$ 6,601,812
Equipment	494,905	494,905
	7,096,717	7,096,717
Less: accumulated amortization	(1,177,444)	(593,019)
	$ 5,919,273	$ 6,503,698

The following is a schedule of future minimum lease payments under capital leases:

Year Ending June 30,	
2015	$ 773,890
2016	739,815
2017	729,999
2018	744,453
2019	759,311
2020-2024	3,779,120
2025-2029	4,055,430
2030-2034	1,848,126
Total minimum lease payments	13,430,144
Less: amount representing interest	(6,854,854)
Present value of minimum lease payments (including current portion of $196,283)	$ 6,575,290

Operating: The Primary Health System rents office space and office equipment under non-cancelable operating leases through 2033, containing various lease terms. The leases have other various provisions, including sharing of certain executory costs. Rent expense under operating leases was approximately $7,840,000 and $7,450,000 in 2014 and 2013, respectively. Future minimum lease commitments at June 30, 2014 for all non-cancelable leases with terms in excess of one year are as follows:

Year Ending June 30,	
2015	$ 6,200,885
2016	3,539,847
2017	3,434,456
2018	2,666,047
2019	2,436,867
Thereafter	19,823,183
	$ 38,101,285

Rental Revenues: The Primary Health System leases office space to physicians and others under various lease agreements with terms in excess of one year. Rental revenue recognized for the years ended June 30, 2014 and 2013 totaled approximately $3,688,000 and $4,261,000, respectively. The following is a schedule of future minimum lease payments to be received for the years ending June 30:

Year Ending June 30,	
2015	$ 1,915,427
2016	1,140,038
2017	748,170
2018	533,963
2019	413,203
Thereafter	1,302,421
	$ 6,053,222

NOTE N--DERIVATIVE FINANCIAL INSTRUMENTS

Simultaneous with the issuance of the $85,000,000 Series 2004 bonds discussed in Note G, the Primary Health System entered into interest rate swap agreements. In an effort to take advantage of the differences between taxable and tax-exempt debt, and manage exposure to interest rate risks associated with various debt instruments, the Primary Health System is currently a party to two distinct interest rate swap agreements with a third party.

With respect to the 1997A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System receives a variable rate equal to the one-month LIBOR-BBA rate and pays a fixed rate equal to 5.087% on a notional amount of $41,000,000. Unless terminated at an earlier date (at the Primary Health System's option), this agreement terminates on October 1, 2027.

With respect to the 1998A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System receives a fixed rate of 3.932% and pays a variable rate equal to the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Index on a notional amount of $16,305,000. Unless terminated at an earlier date (at the Primary Health System's option), this agreement terminates on October 1, 2027.

Although these swap instruments are intended to manage exposure to interest rate risks associated with the various debt instruments referred to above, none of these swap agreements have been determined to be effective hedges. Accordingly, the interest rate swaps are reflected in the accompanying combined statements of net position at their aggregate fair value (a net liability of $3,982,646 and $4,856,429 at June 30, 2014 and 2013, respectively) and the changes in the value of the swaps are reflected as a component of non-operating revenues in the combined statements of revenue, expenses and changes in net position.

Management has considered the effects of any credit value adjustment and while management believes the estimated fair value of the interest rate swap agreements is reasonable, the estimate is subject to change in the near term.

NOTE O--MANAGEMENT AGREEMENT

On April 13, 2011, the Primary Health System's Board of Trustees approved a resolution authorizing a management agreement (the Agreement) between the Primary Health System, Hutcheson Medical Center, Inc. and affiliates (collectively, Hutcheson) and the Hospital Authority of Walker, Dade and Catoosa Counties in Georgia (the Hospital Authority).

Under the terms of the Agreement, the Primary Health System proposed general operating policies and directives for Hutcheson; was responsible for the day-to-day management of Hutcheson and provided oversight of ancillary aspects of Hutcheson, such as physician practices, education, research, and clinical services. The Agreement's initial term was to be through March 31, 2021 with the Primary Health System to have the option to extend the agreement for two additional five year terms. The Primary Health System was authorized to terminate the Agreement, without cause, upon written notice at any point subsequent to May 25, 2013. Upon such termination, Hutcheson was to be obligated to make a Termination Payment to the Primary Health System consisting of all expenses then owed by Hutcheson and any outstanding advances under a Line of Credit Agreement, discussed below. Hutcheson could also terminate the agreement without cause at any point subsequent to May 25, 2013 by paying the Termination Payment, as well as the lesser of a) $1,000,000 per year for each year the Agreement has been in place, or b) $1,000,000 less any management fees paid in each Agreement year.

In addition to the Agreement, the Primary Health System agreed to extend a Line of Credit (the Line) to the Hospital Authority. The maximum amount available under the initial Line was $20,000,000. During the year ending June 30, 2013, the Agreement was amended to increase the maximum amount to $20,550,000. At June 30, 2014, the draws on the Line totaled $20,550,000.

The Line called for interest only payments each month on the outstanding balance, based on the London InterBank Offered Rate plus 4% or a rate of 5%, whichever is greater. However, any unpaid interest through March 31, 2013 was deferred and to be paid over a twelve-month period commencing on that date. All outstanding draws were due at the maturity date, which is consistent with the Agreement termination dates, discussed above.

The Line is secured by a Security Agreement on the primary Hutcheson medical campus. Further, the Counties of Walker and Catoosa, Georgia (collectively, the Counties) have provided additional security in the form of guarantees under an Intergovernmental Agreement. Under the Intergovernmental Agreement, the Counties have each agreed to a maximum liability of $10,000,000 to secure the line. The form of such guarantee was to be at the option of the Counties and were to become enforceable upon a notice of default delivered by the Primary Health System. The form of the guarantee selected by the Counties can include a) a payment of 50% by each County of the amounts owing under the Line, b) payments as they become due up to the respective $10,000,000 limits or c) after non-Judicial foreclosure under the Security

Agreement, each County could elect to pay 50% of any deficiency between the amount outstanding under the Line and the then fair market value. Both Counties previously agreed to levy annual property taxes, if needed to honor these guarantees.

In June 2013, the Agreement was modified to allow Hutcheson to issue requests for proposals for the lease or sale of Hutcheson properties without creating a breach of the Agreement. As part of the Agreement, Hutcheson committed to obtain alternative financing and repay the line of credit upon the earlier of the replacement financing being obtained by Hutcheson, or June 1, 2014.

In August of 2013, however, Hutcheson terminated the Agreement. In response thereto, the Primary Health System declared Hutcheson to be in default under the Agreement and made formal demand of Hutcheson as to all amounts then due and payable. In February 2014, the Primary Health System filed suit against Hutcheson in order to collect the moneys, including principal, interest and penalties, then due. In response to such filing, Hutcheson has asserted multiple counter claims against the Primary Health System alleging mismanagement and other failures under the Agreement. Additionally, another senior creditor has filed a separate lawsuit against the Primary Health System alleging priority over the Primary Health System's security interest and, presumably, the County guarantees relating to Hutcheson. The litigation is currently pending in the United States District Court in the Northern District of Georgia, Rome Division

NOTE P--OTHER REVENUE

The American Recovery and Reinvestment Act of 2009 and the Health Information Technology for Economic and Clinical Health (HITECH) Act established incentive payments under the Medicare and Medicaid programs for certain healthcare providers that use certified Electronic Health Record (EHR) technology. To qualify for incentive payments, healthcare providers must meet designated EHR meaningful use criteria as defined by the Centers for Medicare & Medicaid Services (CMS). Incentive payments are awarded to healthcare providers who have attested to CMS that applicable meaningful use criteria have been met. Compliance with meaningful use criteria is subject to audit by the federal government or its designee and incentive payments are subject to adjustment in a future period.

The Primary Health System recognizes revenue for EHR incentive payments when substantially all contingencies have been met. During 2014 and 2013, the Primary Health System recognized approximately $4,220,000 and $2,670,000, respectively, of other revenue related to EHR incentive payments.

NOTE Q--CONDENSED FINANCIAL INFORMATION

The following is condensed, financial information related to the discretely presented component units as of and for the years ended June 30, 2014 and 2013:

	ContinuCare	*Cyberknife*
As of June 30, 2014		
Due from other governments	$ 192,950	$ 176,300
Other current assets	10,345,848	460,017
Total Current Assets	10,538,798	636,317
Net property, plant and equipment	4,885,489	4,120,144
Other assets	882,663	64,013
Total Assets	$ 16,306,950	$ 4,820,474
Due to other governments	$ 126,882	$ -
Other current liabilities	2,564,259	655,526
Total Current Liabilities	2,691,141	655,526
Long-term debt and capital lease obligations	51,653	3,092,057
Total Liabilities	2,742,794	3,747,583
Net position		
Unrestricted	8,759,244	556,940
Net investment in capital assets	4,804,912	515,951
Total Net Position	13,564,156	1,072,891
Total Liabilities and Net Position	$ 16,306,950	$ 4,820,474
Year Ended June 30, 2014		
Net patient and operating revenue	$ 26,429,529	$ 1,900,600
Operating expenses:		
Salaries, wages and benefits	13,407,246	231,342
Supplies and other expenses	12,497,767	702,098
Depreciation	549,539	560,208
Total Operating Expenses	26,454,552	1,493,648
Operating Income (Loss)	(25,023)	406,952
Nonoperating revenue (expenses)	389,611	(172,007)
Change in Net Position	364,588	234,945
Net Position at Beginning of Period	13,199,568	837,946
Net Position at End of Period	$ 13,564,156	$ 1,072,891

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

	ContinuCare	Cyberknife
As of June 30, 2013		
Due from other governments	$ 248,239	$ 129,000
Other current assets	8,865,703	490,008
Total Current Assets	9,113,942	619,008
Net property, plant and equipment	5,174,936	4,468,880
Other assets	2,383,609	75,309
Total Assets	$ 16,672,487	$ 5,163,197
Due to other governments	$ 408,032	$ 120,000
Other current liabilities	3,035,595	788,584
Total Current Liabilities	3,443,627	908,584
Long-term debt and capital lease obligations	29,292	3,416,667
Total Liabilities	3,472,919	4,325,251
Net position		
Unrestricted	8,110,622	210,424
Net investment in capital assets	5,088,946	627,522
Total Net Position	13,199,568	837,946
Total Liabilities and Net Position	$ 16,672,487	$ 5,163,197
Year Ended June 30, 2013		
Net patient and operating revenue	$ 26,026,863	$ 1,560,900
Operating expenses:		
Salaries, wages and benefits	13,395,486	211,954
Supplies and other expenses	12,897,677	578,266
Depreciation	517,483	527,752
Total Operating Expenses	26,810,646	1,317,972
Operating Income (Loss)	(783,783)	242,928
Nonoperating revenue (expenses)	497,259	(194,623)
Change in Net Position	(286,524)	48,305
Net Position at Beginning of Period	13,486,092	789,641
Net Position at End of Period	$ 13,199,568	$ 837,946

ContinuCare owes the Primary Health System for various services, supplies, and rents provided, or expenses paid on its behalf. Actual expenses incurred related to these services were $1,925,245 and $2,119,466 in 2014 and 2013, respectively. In addition, ContinuCare provides staffing, contract nurse visits, and administrative services to the Primary Health System. Revenues from such services were $372,554 and $617,427 for the years ended 2014 and 2013, respectively. Amounts due at June 30, 2014 and 2013 are included in amounts due to/from other governments in the accompanying combined financial statements.

As of June 30, 2014 and 2013, Cyberknife owes the Primary Health System for various services, supplies and rents provided, or expenses paid on its behalf. The Primary Health System owes Cyberknife for radiation services provided by Cyberknife to the Primary Health System's patients. Revenues related to those services provided to the Primary Health System were $1,900,600 and $1,560,900 in 2014 and 2013, respectively. Amounts due at June 30, 2014 and 2013 are included in amounts due to/from other governments in the accompanying combined statements of net position.

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before February 10, 2015, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger East Hospital, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to modernize the CON originally issued in 2004 (no. CN0405-047AE) by upgrading the Cardiac Catheterization Lab to perform interventional cardiac procedures from the already approved diagnostic cardiac procedures at Erlanger East Hospital. If approved, the number of approved cardiac catheterization labs in the service area will remain the same. The expansion of Erlanger East Hospital (CON No. CN0405-047AE) is in process. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger East Hospital, 1755 Gunbarrel Road, Chattanooga, Hamilton County, Tennessee, 37421. The total project cost is estimated to be $ 303,000.00.

The anticipated date of filing the application is February 13, 2015.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	February 5, 2015	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Original

ADDITIONAL INFORMATION

Erlanger Health System

CN1502-005

CLARIFYING INFORMATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger East Hospital

Application To Modernize The Certificate Of Need
Originally Issued In 2004 (No. CN0405-047AE)
By Upgrading the Cardiac Catheterization Lab To Perform
Interventional / Therapeutic Procedures In The Already
Approved Diagnostic Cardiac Catheterization Laboratory

Application Number CN1502-005

March 2, 2015

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Clarifying Information To The
Tennessee Health Services & Development Agency

1.) Section C.1, Need (Specific Need Criteria – Cardiac Catheterization), Item 8.

Response

With the second supplemental information submitted on February 26, 2015, applicant stated that we would submit the "weighted" cases data as "clarifying information" when it is received from the Tennessee Dept. of Health. Applicant received the TDOH report On Monday, March 2, 2015. Therefore, we are submitting it to the Agency and it is attached.

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger East Hospital

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental / clarifying information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 2nd of March (Month), 2015 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

TABLE OF ATTACHMENTS

** NOTE - The attachments are paginated and the page number begins with "A". The page number appears in the upper right hand corner of the page.

ATTACHMENTS

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Data Sources: TDH Hospital Discharge Data System (HDDS)
Data Years: 2011-2013 (most recent years of finalized HDDS data)

Methodology: Determine the three year Cardiac Cath weighted volume (diagnostic and therapeutic) performed by each Tennessee hospital in the service area by 13 age groups calculating a single year average. Include all patients seen, both Tennessee resident and non-resident. Include all occurrences of Cardiac Cath ICD-9 Procedure Codes or CPT HCPCS codes with a Revenue Code 0481, Cardiology - Cardiac Cath Lab. Summarize cases based on the highest weighted code.

Cardiac Cath ICD-9 and CPT codes and categorizations determined by the Bureau of TennCare and the Tennessee Hospital Association. Note: there was a major shift in CPT coding beginning in 2011.

The service area for the current application includes Bradley and Hamilton counties. Acute care hospitals found in this area (during the years 2011-2013) are Skyridge Medical Center, Skyridge Medical Center Westside, Erlanger Medical Center, Erlanger North, Erlanger East, Memorial North Park, Memorial Healthcare System, Parkridge Medical Center and Parkridge East Hospital.

Skyridge Medical Center Westside (State ID 06233) did not record any claims in the time period with Revenue Code 0481, Cardiology - Cardiac Cath Lab.

Skyridge Medical Center (State ID 06223)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2011-2013

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	593.5	592.0	1.5	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	4.0	4.0	0.0	0.0
30 - 39	7.0	7.0	0.0	0.0
40 - 44	35.0	35.0	0.0	0.0
45 - 49	49.0	49.0	0.0	0.0
50 - 54	73.0	73.0	0.0	0.0
55 - 59	85.0	85.0	0.0	0.0
60 - 64	80.0	80.0	0.0	0.0
65 - 69	96.0	96.0	0.0	0.0
70 - 74	75.0	75.0	0.0	0.0
75 - 79	50.0	50.0	0.0	0.0
80 - 84	33.0	33.0	0.0	0.0
85 +	6.5	5.0	1.5	0.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	237.0	6.0	219.0	12.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	4.0	0.0	0.0	4.0
30 - 39	3.0	0.0	3.0	0.0
40 - 44	9.0	0.0	9.0	0.0
45 - 49	22.0	0.0	18.0	4.0
50 - 54	21.0	0.0	21.0	0.0
55 - 59	26.0	2.0	24.0	0.0
60 - 64	42.0	0.0	42.0	0.0
65 - 69	36.0	0.0	36.0	0.0
70 - 74	18.0	0.0	18.0	0.0
75 - 79	41.0	4.0	33.0	4.0
80 - 84	15.0	0.0	15.0	0.0
85 +	0.0	0.0	0.0	0.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

* Cardiac Cath ICD-9, CPT codes and service categories provided by the Bureau of TennCare and the Tennessee Hospital Association.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospital Discharge Data System, 2011-2013. Nashville, TN.

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Erlanger Medical Center (State ID 33203)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2011-2013

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	4,367.5	4,042.0	43.5	282.0
0 - 17	140.0	136.0	0.0	4.0
18 - 29	36.0	30.0	0.0	6.0
30 - 39	156.0	141.0	3.0	12.0
40 - 44	252.5	235.0	1.5	16.0
45 - 49	397.5	382.0	1.5	14.0
50 - 54	605.5	567.0	10.5	28.0
55 - 59	645.5	587.0	4.5	54.0
60 - 64	661.0	617.0	6.0	38.0
65 - 69	565.5	528.0	7.5	30.0
70 - 74	415.5	377.0	4.5	34.0
75 - 79	292.0	261.0	3.0	28.0
80 - 84	146.5	133.0	1.5	12.0
85 +	54.0	48.0	0.0	6.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	4,232.0	554.0	3,174.0	504.0
0 - 17	118.0	104.0	6.0	8.0
18 - 29	34.0	2.0	12.0	20.0
30 - 39	177.0	10.0	147.0	20.0
40 - 44	257.0	14.0	219.0	24.0
45 - 49	357.0	24.0	297.0	36.0
50 - 54	630.0	62.0	540.0	28.0
55 - 59	661.0	62.0	531.0	68.0
60 - 64	617.0	76.0	453.0	88.0
65 - 69	518.0	80.0	378.0	60.0
70 - 74	393.0	50.0	267.0	76.0
75 - 79	271.0	54.0	177.0	40.0
80 - 84	127.0	10.0	93.0	24.0
85 +	72.0	6.0	54.0	12.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

* Cardiac Cath ICD-9, CPT codes and service categories provided by the Bureau of TennCare and the Tennessee Hospital Association.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospital Discharge Data System, 2011-2013. Nashville, TN.

Erlanger North (State ID 33213)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2011-2013

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	1.0	1.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	1.0	1.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	0.0	0.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	0.0	0.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	0.0	0.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

* Cardiac Cath ICD-9, CPT codes and service categories provided by the Bureau of TennCare and the Tennessee Hospital Association.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospital Discharge Data System, 2011-2013. Nashville, TN.

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Erlanger East (State ID 33233)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2011-2013

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	1.0	1.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	1.0	1.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	0.0	0.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	0.0	0.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	0.0	0.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

* Cardiac Cath ICD-9, CPT codes and service categories provided by the Bureau of TennCare and the Tennessee Hospital Association.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospital Discharge Data System, 2011-2013. Nashville, TN.

Memorial North Park (State ID 33223)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2011-2013

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	108.5	105.0	1.5	2.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	3.0	3.0	0.0	0.0
40 - 44	2.0	2.0	0.0	0.0
45 - 49	8.0	8.0	0.0	0.0
50 - 54	10.0	10.0	0.0	0.0
55 - 59	9.0	9.0	0.0	0.0
60 - 64	11.5	10.0	1.5	0.0
65 - 69	12.0	10.0	0.0	2.0
70 - 74	14.0	14.0	0.0	0.0
75 - 79	16.0	16.0	0.0	0.0
80 - 84	13.0	13.0	0.0	0.0
85 +	10.0	10.0	0.0	0.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	125.0	2.0	123.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	9.0	0.0	9.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	9.0	0.0	9.0	0.0
50 - 54	15.0	0.0	15.0	0.0
55 - 59	9.0	0.0	9.0	0.0
60 - 64	6.0	0.0	6.0	0.0
65 - 69	20.0	2.0	18.0	0.0
70 - 74	12.0	0.0	12.0	0.0
75 - 79	18.0	0.0	18.0	0.0
80 - 84	18.0	0.0	18.0	0.0
85 +	9.0	0.0	9.0	0.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

* Cardiac Cath ICD-9, CPT codes and service categories provided by the Bureau of TennCare and the Tennessee Hospital Association.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospital Discharge Data System, 2011-2013. Nashville, TN.

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Memorial Healthcare System (State ID 33323)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2011-2013

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	12,448.5	11,019.0	277.5	1,152.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	30.0	26.0	0.0	4.0
30 - 39	260.0	242.0	0.0	18.0
40 - 44	400.5	376.0	4.5	20.0
45 - 49	721.5	666.0	7.5	48.0
50 - 54	1,120.0	1,046.0	24.0	50.0
55 - 59	1,355.5	1,246.0	25.5	84.0
60 - 64	1,651.5	1,509.0	34.5	108.0
65 - 69	2,127.5	1,862.0	55.5	210.0
70 - 74	1,910.0	1,615.0	51.0	244.0
75 - 79	1,504.0	1,289.0	33.0	182.0
80 - 84	890.0	743.0	27.0	120.0
85 +	478.0	399.0	15.0	64.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	11,591.0	1,632.0	8,379.0	1,580.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	26.0	6.0	12.0	8.0
30 - 39	142.0	26.0	108.0	8.0
40 - 44	290.0	32.0	222.0	36.0
45 - 49	571.0	60.0	471.0	40.0
50 - 54	881.0	102.0	699.0	80.0
55 - 59	1,271.0	144.0	987.0	140.0
60 - 64	1,370.0	194.0	996.0	180.0
65 - 69	1,967.0	310.0	1,437.0	220.0
70 - 74	1,825.0	310.0	1,251.0	264.0
75 - 79	1,601.0	246.0	1,083.0	272.0
80 - 84	1,038.0	120.0	702.0	216.0
85 +	609.0	82.0	411.0	116.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

* Cardiac Cath ICD-9, CPT codes and service categories provided by the Bureau of TennCare and the Tennessee Hospital Association.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospital Discharge Data System, 2011-2013. Nashville, TN.

Parkridge Medical Center (State ID 33383)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2011-2013

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	3,806.0	3,198.0	54.0	554.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	16.0	10.0	0.0	6.0
30 - 39	82.5	73.0	1.5	8.0
40 - 44	130.5	124.0	4.5	2.0
45 - 49	247.0	237.0	0.0	10.0
50 - 54	395.0	347.0	6.0	42.0
55 - 59	436.5	394.0	4.5	38.0
60 - 64	483.0	421.0	6.0	56.0
65 - 69	613.0	516.0	9.0	88.0
70 - 74	559.0	420.0	15.0	124.0
75 - 79	409.0	322.0	3.0	84.0
80 - 84	291.5	225.0	4.5	62.0
85 +	143.0	109.0	0.0	34.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	4,949.0	896.0	3,477.0	576.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	14.0	4.0	6.0	4.0
30 - 39	94.0	10.0	72.0	12.0
40 - 44	138.0	10.0	120.0	8.0
45 - 49	304.0	26.0	270.0	8.0
50 - 54	518.0	64.0	426.0	28.0
55 - 59	553.0	64.0	429.0	60.0
60 - 64	655.0	112.0	483.0	60.0
65 - 69	795.0	162.0	549.0	84.0
70 - 74	706.0	178.0	432.0	96.0
75 - 79	511.0	116.0	315.0	80.0
80 - 84	429.0	98.0	255.0	76.0
85 +	232.0	52.0	120.0	60.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

* Cardiac Cath ICD-9, CPT codes and service categories provided by the Bureau of TennCare and the Tennessee Hospital Association.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospital Discharge Data System, 2011-2013. Nashville, TN.

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Parkridge East Hospital (State ID 33393)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2011-2013

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	14.0	14.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	1.0	1.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	7.0	7.0	0.0	0.0
70 - 74	2.0	2.0	0.0	0.0
75 - 79	2.0	2.0	0.0	0.0
80 - 84	1.0	1.0	0.0	0.0
85 +	1.0	1.0	0.0	0.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	29.0	2.0	27.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	3.0	0.0	3.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	12.0	0.0	12.0	0.0
70 - 74	6.0	0.0	6.0	0.0
75 - 79	3.0	0.0	3.0	0.0
80 - 84	5.0	2.0	3.0	0.0
85 +	0.0	0.0	0.0	0.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

* Cardiac Cath ICD-9, CPT codes and service categories provided by the Bureau of TennCare and the Tennessee Hospital Association.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospital Discharge Data System, 2011-2013. Nashville, TN.

From the 2013 Joint Annual Reports (JAR) of Hospitals there are 16 Cardiac Cath labs in operation in the service area:

Skyridge Medical Center State (ID 06223) – 1 lab
Erlanger Medical Center (State ID 33203) – 4 labs
Memorial Healthcare System (State ID 33323) – 7 labs
Parkridge Medical Center (State ID 33383) – 4 labs

Service Area Hospital	Diagnostic Cardiac Caths	Therapeutic Cardiac Caths	Total Cardiac Caths
Skyridge Medical Center (State ID 06223)	593.5	237.0	830.5
Erlanger Medical Center (State ID 33203)	4,367.5	4,232.0	8,599.5
Erlanger North (State ID 33213)	1.0	0.0	1.0
Erlanger East (State ID 33233)	1.0	0.0	1.0
Memorial North Park (State ID 33223)	108.5	125.0	233.5
Memorial Healthcare System (State ID 33323)	12,448.5	11,591.0	24,039.5
Parkridge Medical Center (State ID 33383)	3,806.0	4,949.0	8,755.0
Parkridge East Hospital (State ID 33393)	14.0	29.0	43.0
Totals	21,340.0	21,163.0	42,503.0

# of Caridac Cath Labs in Service Area (JAR)	16
Capacity per Lab (defined by standards)	2,000
Total Capacity in Service Area	32,000
Percent of Existing Services to Capacity	132.8%

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

March 2, 2015

Joseph M. Winick, Sr. Vice President
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403

RE: Certificate of Need Application -- Chattanooga-Hamilton County Hospital d/b/a Erlanger East Hospital - CN1502-005
To modernize the CON originally issued in 2004 (CN0405-047AE) which was approved for diagnostic cardiac services. The applicant proposes to upgrade the Cardiac Catheterization Lab to also perform interventional cardiac procedures. Erlanger East Hospital is located at 1755 Gunbarrel Road, Chattanooga (Hamilton County), Tennessee 37416. Project cost is $303,000.00.

Dear Mr. Winick:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on March 1, 2015. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on May 28, 2015.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, CON Director, Division of Health Statistics

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: March 2, 2015

RE: Certificate of Need Application
Chattanooga-Hamilton County Hospital d/b/a Erlanger East Hospital - CN1502-005

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on March 1, 2015 and end on May 1, 2015.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Joseph M. Winick, Sr. Vice President

COPY
SUPPLEMENTAL-1

Erlanger Health System
CN1502-005

SUPPLEMENTAL INFORMATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger East Hospital

Application To Modernize The Certificate Of Need
Originally Issued In 2004 (No. CN0405-047AE)
By Upgrading the Cardiac Catheterization Lab To Perform
Interventional / Therapeutic Procedures In The Already
Approved Diagnostic Cardiac Catheterization Laboratory

Application Number CN1502-005

February 24, 2014

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section A, Applicant Profile.

The applicant references attachments but does not place the applicable attachment item number in the body of the application. As directed in the application, please place all attachments at the back of the application in order and reference the applicable item number on all attachments.

Response

In discussion with the reviewer, Mr. Earhart, the attachments as submitted with the CON application are acceptable.

2.) Section A, Applicant Profile, Item 9 – Bed Complement Data.

In the bed complement data chart it is noted the applicant is proposing 113 beds. Please revise and resubmit page 6.

Response

As requested, page 6 has been revised and is attached to this supplemental information.

3.) Section A, Applicant Profile, Item 13.

It is noted the applicant is contracted in the Blue Cross Network E and S. Please provide a brief overview of the two plans and why this is significant to this application.

It is noted the applicant is contracted with "United Healthcare e". Please clarify if the "e" is a typo.

The applicant indicates Erlanger has contracts with Cover Kids and Cover TN. Please clarify if these two plans are still active.

Response

Blue Cross Network S is a lower cost network limited to 2 participating hospitals in our market. Blue Cross Network E is the lowest cost network on the exchange and Erlanger is the only participating hospital in our market. These plans are significant to the CON application because they are the plans which serve the vulnerable populations in southeast Tennessee. Without these plans these populations may have difficulty accessing needed healthcare services.

Parts of Cover Tennessee are still active. CoverKids and AccessTN are still active networks. CoverTN ended on January 1, 2014, when the insurance exchange became active.

There is not a "United Healthcare e", this was simply a typing error. Page 8 has been revised and is attached to this supplemental information.

4.) Section B, Project Description, Item I.

It is noted the Medical Director of Erlanger's Cardiology service has indicated that it is safer to conduct the therapeutic intervention concurrently than to transfer the patient to another hospital where a second intervention would be required. Please discuss the risks of transferring patients to another hospital for a second intervention.

Response

Transferring a patient with an arterial sheath in place poses a significant risk for arterial damage, bleeding and/or infection. If the sheath is removed from the patient before transfer to Erlanger Medical Center, there is a significant risk for infection and bleeding. This is only compounded by additional potential complications that may occur from a second arterial stick in order to perform the therapeutic (interventional) procedure. Further, there are potential risks if the patient is put under anesthesia twice instead of just one time.

5.) Section B, Project Description, Item II.B.

The applicant states Erlanger East Hospital holds a CON for the transfer up to 70 additional beds from Erlanger Medical Center. Earlier in the application, the applicant states the number was 79. Please clarify.

Response

The CON application in 2004 was approved to transfer a total of 79 beds. Of the 79 beds which were approved, a total of 9 beds have transferred so far. Therefore, a total of up to 70 beds may still be transferred to *Erlanger East Hospital*.

6.) Section B, Project Description, Item II.E 1.b and 1.3.

The hours of operation for the proposed service are noted. However, please clarify why the proposed service will not be open from 5 pm-7 am, and not open on weekends. During those times where will patients who need therapeutic intervention services be referred?

Response

Only pre-screened, low risk elective cardiac patients will be catheterized at *Erlanger East Hospital*. Emergent cardiac patients who arrive at *Erlanger East Hospital* will be transferred to *Erlanger Medical Center*, please see the transfer policy attached to the original CON application, (p. A-93).

As noted in the CON application, Erlanger East Hospital is licensed, and operates as, a satellite facility of *Erlanger Medical Center*. As such, the hospital is available 24 hours per day, 7 days per week.

7.) Section C.1, Need (Specific Criteria – Cardiac Catheterization) Item 3.

The transfer agreement with Erlanger East is noted. Please complete the following table:

Hospital	Distance From Erlanger East	Emergency Travel Time from Erlanger East to Erlanger Hospital by ground	2014 # Transfers for open heart surgery	2014 # Transfers for therapeutic catheterization
Erlanger Hospital				

In the transfer policy and procedure, Puckett EMS is listed as the first EMS to be contacted for emergency transfer. Please discuss why this EMS provider is listed as first and what expertise Puckett EMS has in the transfer of cardiac patients.

Response

As requested, the table appears below.

Hospital	Distance From Erlanger East	Emergency Travel Time from Erlanger East to Erlanger Hospital by ground	2014 # Transfers for open heart surgery	2014 # Transfers for therapeutic catheterization
Erlanger Hospital	9.4 Miles	Approximately 17 minutes.	0	0

Please note that there were not any cardiac patient transfers in 2014 because the cardiac catheterization laboratory at *Erlanger East Hospital* is not yet in operation.

As to the transport service, Puckett EMS is listed as the first transport because Erlanger has a contract with this EMS provider. The contract stipulates that they will be on site within 6 minutes of notification and will transfer the patient. If Puckett EMS is unable to transport the patient, they will notify another EMS service.

All EMS providers are BLS and ACLS certified to care for cardiac patients, please see the transfer policy attached to the original CON application, (p. A-93). Further, Puckett EMS operates other EMS services in Tennessee. The backup to Puckett EMS is the Hamilton County EMS service.

8.) Section C.1, Need (Specific Criteria - Cardiac Catheterization) Item 7.

Please clarify what would be "adequate staff" for the proposed project.

Response

The Cardiac Catheterization Laboratory at *Erlanger East Hospital* will be staffed with four (4) Cardiac Specialists. This staff complement is adequate for the catheterization service.

9.) Section C.1, Need (Specific Criteria - Cardiac Catheterization) Item 8.

The applicant is adding additional cardiac services. Please address by listing each cardiac catheterization provider's utilization in the proposed service area and comparing to the 70% capacity standard (70% of 2000 cases).

Response

There are no other Cardiac Catheterization Laboratories in the defined service area. However, in discussion with Mr. Earhart, he would like the catheterization laboratories in Hamilton County, Tennessee. The table appears below.

	Cardiac Catheterization Laboratories General Utilization								
	==== Erlanger Med Ctr ====			==== Memorial Hosp =====			=== Parkridge Med Ctr ====		
	2013	2012	2011	2013	2012	2011	2013	2012	2011
Data From Joint Annual Reports									
Catheterizations	2,284	1,678	1,974	4,284	4,428	4,345	2,045	2,347	1,964
PTCA	628	508	689	85	100	104	880	1,026	788
Stents	357	412	644	1,374	1,490	1,505	1,053	930	690
Other	525	638	821	4,031	4,921	6,275	890	1,296	1,153
Total	3,794	3,236	4,128	9,774	10,939	12,229	4,868	5,599	4,595
Summary Information									
Cardiac Catheterizations - Diagnostic	2,284	1,678	1,974	4,284	4,428	4,345	2,045	2,347	1,964
Cardiac Catheterizations - Interventional	985	920	1,333	1,459	1,590	1,609	1,933	1,956	1,478
Cardiac Catheterizations - Other	525	638	821	4,031	4,921	6,275	890	1,296	1,153
Cardiac Catheterizations - Total	3,794	3,236	4,128	9,774	10,939	12,229	4,868	5,599	4,595
Number Of Rooms	4	4	4	7	7	7	4	4	4
Average Procedures Per Room	949	809	1,032	1,396	1,563	1,747	1,217	1,400	1,149
Unweighted Utilization Of Capacity Std.	47.4%	40.5%	51.6%	69.8%	78.1%	87.4%	60.9%	70.0%	57.4%

** NOTES - (1) Data derived from Tennessee Joint Annual Reports For Hospitals.

It should be noted that the detail data required to weight the catheterization procedures is not available for *Memorial Hospital* and *Parkridge Medical Center*. Therefore, we have provided an unweighted utilization ratio.

10.) Section C.1, Need (Specific Criteria - Therapeutic Cardiac Catheterization) Item 14.

The applicant has only provided Year One and Year Two projected utilization. However, annual volume shall be measured upon a two year average beginning at the conclusion of the applicant's first year of operation. Please revise.

Response

The need for the cardiac catheterization service at *Erlanger East Hospital* will meet the minimum volume standard. Following is the estimated volume of low risk interventional catheterization patients at *Erlanger East Hospital*.

	Interventional Patients	Total Patients
Year 1	127	509
Year 2	132	527
Year 3	136	545
Year 4	141	563
Year 5	145	581
Average - Years 1-2	130	518
Average - Years 2-3	134	536
Average - Years 3-4	139	554
Average - Years 4-5	143	572

11.) Section C.1, Need (Specific Criteria - Therapeutic Cardiac Catheterization) Item 15.

Please clarify if a formal transfer agreement with an open heart tertiary center will be maintained. If so, please indicate the name of the open heart tertiary center.

Response

As noted in the CON application, *Erlanger East Hospital* is licensed, and operates as, a satellite facility of *Erlanger Medical Center*. *Erlanger Medical Center* is the tertiary referral center for southeast Tennessee. As such, *Erlanger East Hospital* has access to transfer catheterization patients for open heart surgery tertiary services directly to *Erlanger Medical Center*.

12.) Section C.1, Need (Specific Criteria - Therapeutic Cardiac Catheterization) Item 16.

Please provide the following information for the Erlanger cardiologists that will perform the proposed cardiac therapeutic catheterizations: 1) estimated number of diagnostic cardiac procedures conducted for each of the past five (5) years, and 2) the estimated number of therapeutic cardiac procedures conducted for each of the past five (5) years.

Please provide the names and credentials (i.e., curriculum vitae's and Board Certificates) for the physicians on the hospital's medical staff who will be performing these procedures. Please note those physicians who are board certified invasive and/or interventional cardiologists.

Response

The cardiologists which will practice in the *Erlanger East Hospital* catheterization laboratory, are:

John V. Golding, III, M.D.
Walter L. Few, III, M.D.
John C. Hemphill, M.D.
Robert L. Huang, M.D., M.P.H.
Poonam Puri, M.D.

A Curriculum Vitae for each cardiologist is attached to this supplemental information.

The number of diagnostic and therapeutic catheterizations for each cardiologist for the past 5 years, is as follows.

	Diagnostic	Therapeutic
Dr. Golding	463	308
Dr. Few	454	239
Dr. Hemphill	452	316
Dr. Huang	551	340
Dr. Puri	464	286

13.) Section C.1, Need (Specific Criteria - Therapeutic Cardiac Catheterization) Item 17.

Please clarify if the applicant plans to ever provide therapeutic services on an emergency basis (24/7) in the future. If not, why?

Response

There are not currently any plans in the foreseeable future to provide therapeutic services on an emergency basis (24/7) at *Erlanger East Hospital*. This is because all of the emergency teams are already in place at Erlanger Medical Center and the cost of duplicating this on-call coverage is deemed to be prohibitive.

14.) Section C.1, Need (Specific Criteria - Therapeutic Cardiac Catheterization) Item 18.

Please indicate the number of diagnostic catheterization cases reported to the Tennessee Dept. of Health by Erlanger East for the last two reporting periods.

Response

There were not any diagnostic catheterization cases reported to the Tennessee Dept. of Health for the last 2 reporting periods. This is because the cardiac catheterization laboratory at *Erlanger East Hospital* is not yet in operation.

15.) Section C, Need, Item 3.

The county level map of the applicant's service area is noted. However, please submit a revised map with only the counties in the proposed service area

identified. In addition, please label Georgia service area counties.

The applicant has defined ten zip codes in the proposed service area. Please provide a map of the 10 zip codes in relation to the proposed 2 County service area.

Response

The maps for both the zip code level and county level service areas are attached to this supplemental information.

16.) Section C, Item 4.A.

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	*Hamilton*	*Bradley*	*Service Area*	*TN*
Current Year (2015), Age 65+				
Projected Year (2019), Age 65+				
Age 65+, % Change				
Age 65+, % Total (2019)				
2015, Total Population				
2019, Total Population				
Total Pop. % Change				
TennCare Enrollees				
TennCare Enrollees as a % of Total Population				
Median Age				
Median Household Income				
Population % Below Poverty Level				

Response

The updated table appears below, as requested.

	Hamilton	Bradley	Service Area	State Of Tennessee
Current Year (2015) - Age 65+	57,974	16,985	74,959	1,012,937
Projected Year (2019) - Age 65+	64,174	19,036	83,210	1,134,565
Age 65+ - % Change	10.7%	12.1%	11.0%	12.0%
Age 65+ - % Total	16.6%	16.3%	16.5%	15.2%
Total Pop. - 2015	349,273	104,364	453,637	6,649,438
Total Pop. - 2019	354,610	108,511	463,121	6,894,997
Total Pop. - % Change	1.5%	4.0%	2.1%	3.7%
Median Age	38	38	38	38
Median Household Income	$46,702	$41,083	$45,482	$44,298
TennCare Enrollees	61,399	20,321	81,720	1,331,838
TennCare Enrollees As % Of Total Pop.	17.6%	19.5%	18.0%	20.0%
Persons Below Poverty Level	59,979	20,664	80,643	1,170,301
Persons Below Poverty Level As % Of Total Pop.	17.2%	19.8%	17.8%	17.6%

17.) Section C, Need, Item 4.B.

Please identify any medically underserved areas in the proposed service area.

Response

The areas of Hamilton County and Bradley County which as designated as Medically Underserved Areas were identified in the attachment to the original CON application (p. A-89). It should be noted that in discussion with Mr. Earhart, these areas are identified by census tract and not by zip code. However, generally speaking, these areas correspond with the service area for *Erlanger East Hospital*.

18.) Section C, Need, Item 5.

Please describe existing cardiac catheterization services in Hamilton and Bradley Counties.

Please complete the following chart for Hamilton and Bradley counties:

Provider Name	Diagnostic Cath Cases			Therapeutic Cath Cases			Open Heart Surgeries		
	2011	2012	2013	2011	2012	2013	2011	2012	2013

Total									

Response

In Hamilton County, there are three competing hospitals (Erlanger, Memorial & Parkridge) which provide the same level of cardiac catheterization services (diagnostic, therapeutic and emergent STEMI). Of the three institutions, only Erlanger Health System is Joint Commission Accredited for AMI (Acute Myocardial Infarction) care. Also noteworthy, is this Joint Commission accreditation is only held by two hospitals in the state of Tennessee. In Bradley County, SkyRidge Medical Center provides diagnostics and therapeutic cardiac catheterization services; however, they are unable to provide 24/7 STEMI coverage at the present time.

The data table requested is below.

	= Diagnostic Cath Cases ==			= Therapeutic Cath Cases ==			== Open Heart Surgeries ==		
	2013	2012	2011	2013	2012	2011	2013	2012	2011
Erlanger Medical Center	2,284	1,678	1,974	985	920	1,333	245	250	256
Memorial Hospital	4,284	4,428	4,345	1,459	1,590	1,609	737	808	794
Parkridge Medical Center	2,045	2,347	1,964	1,933	1,956	1,478	246	308	275
Skyridge Medical Center	132	234	274	35	40	44	0	0	0
Total	8,745	8,687	8,557	4,412	4,506	4,464	1,228	1,366	1,325

** NOTES - (1) Data derived from Tennessee Joint Annual Reports For Hospitals.

19.) Section C, Need, Item 6.

Please complete the following chart.

Erlanger Medical Ctr.	2004	05	06	07	08	09	10	11	12	13	14	15	16	2017
Diagnostic Caths														
Therapeutic Caths														
Total														

Please provide details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Please complete the following table for Erlanger East patient origin by zip code for CY 2014 for zip codes with patient origin over 5%.

Patient Zip Code	Patient City	Patient County	Total	Cumulative Patients	% by Zip Code	Cumulative %
Service Area Sub-Total						
Other Patients						
Grand Total						

Response

Please note that *Erlanger Health System* installed a new information system for the Cardiac Catheterization Laboratories in 2012. As a result of this, we are not able to provide the requested information going back to 2004. However, the information is provided beginning in 2011 and the information requested is below. The forecast for the number of cardiac catheterizations at Erlanger Medical Center appears below. It is based on an average use rate for the 3 year period of CY 2011 through CY 2013. The use rate is calculated based on the population in the regional service area age 65+.

	2011	2012	2013	Average Use Rate	2014	2015	2016	2017
Population Age 65+ - Regional Service Area	129,416	130,412	131,408		132,404	133,400	134,396	135,392
Use Rate - Diagnostic	0.015253	0.012867	0.017381	0.015167				
Use Rate - Interventional	0.010300	0.007055	0.007496	0.008284				
Use Rate - Other	0.006344	0.004892	0.003995	0.005077				
Erlanger Medical Center								
Cardiac Catheterizations - Diagnostic	1,974	1,678	2,284		2,008	2,023	2,038	2,053
Cardiac Catheterizations - Interventional	1,333	920	985		1,097	1,105	1,113	1,122
Cardiac Catheterizations - Other	821	638	525		672	677	682	687
Cardiac Catheterizations - Total	4,128	3,236	3,794		3,777	3,805	3,833	3,862

The table for patient origin at Erlanger East Hospital is below. However, please note that this information reflects primarily Obstetric patients for 2014 because that is the patient population which Erlanger East Hospital currently serves. The patient origin information is expected to change once the expansion project is completed.

Zip Code	Patient City	Patient County	Total	Cumulative Total	% By Zip Code	Cumulative %
37421	Chattanooga, TN	Hamilton County	238	238	11.3%	11.3%
37363	Ooltewah, TN	Hamilton County	163	401	7.8%	19.1%
37343	Hixson, TN	Hamilton County	139	540	6.6%	25.7%
		Sub-Total	541		25.7%	25.7%
		Other Patients	2,099		74.3%	100.0%
		Total	2,640		100.0%	

20.) Section C, Economic Feasibility, Item 1, Project Cost Chart.

The moveable equipment cost of $300,000 is noted. However, please list all equipment over $50,000.

The applicant has specified Technical, Signage, and Environmental in line A.9 with no value assigned. Please clarify.

Response

There is not expected to be any moveable equipment over $ 50,000 as a result of this upgrade of the cardiac catheterization laboratory.

The description appearing on line A-9 of the Project Cost Chart was an oversight, page 51 of the CON application has been revised and is attached to this supplemental information.

21.) Section C, Economic Feasibility, Item 2.

The applicant notes the proposed project will be funded from continuing operation. However, what is the plan if the applicant's net income is less than expected in Year One and Year Two.

Response

Applicant does not expect that the net income will be less than expected. However, in the unlikely event that this should occur, *Erlanger Health System* has in excess of $ 100 Million in cash reserves to smooth such a possibility.

22.) Section C, Economic Feasibility, Item 1 - Historical & Projected Data Charts.

Please complete a Projected Data Chart for the total cath lab which includes both diagnostic and therapeutic catheterizations.

The Historical Data Chart and Projected Data Charts are noted. Please complete the following tables and place the tables on separate pages labeled 54A and 55A, respectively to be located after the Historical and Projected Data Charts.

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES

	Year___	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	*Year*____
1.	$_____	$_____	*$*_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	*$*_____

Response

The detail for other expenses related to the *Historical Data Chart* and the *Projected Data Chart* is attached to this supplemental information.

23.) Section C, Economic Feasibility, Question 6.B.

Please compare the proposed cardiac therapeutic catheterization charges to Erlanger Hospital and recently approved Dyersburg Regional Medical Center (DRMC), CN1403-007A.

Response

As requested, select charges related to cardiac catheterization for *Erlanger East Hospital* are compared to the charges for Dyersburg Regional Medical Center. The table is below.

Charge Code	Description	CPT Code	UB Revenue Code	EHS Charge Amount	Dyersburg Charge Amount
50180561	PTCA LC	92920	480	8294.00	24089.42
50180843	PTCA LD	92920	480	8294.00	24089.42
50180553	PTCA LM	92920	480	8294.00	24089.42
50180579	PTCA RC	92920	480	8294.00	24089.42
50180835	PTCA RI	92920	480	8294.00	24089.42
50180595	PTCA LC ADD VESSEL/BRNCH	92921	480	4684.00	19271.54
50180850	PTCA LD ADD VESSEL/BRNCH	92921	480	4684.00	19271.54
50180603	PTCA RC ADD VESSEL/BRNCH	92921	480	4684.00	19271.54
50180587	PTCA RI ADD VESSEL/BRNCH	92921	480	4684.00	19271.54
50180629	ATHERECTOMY/PTCA LC	92924	480	18081.00	35968.46
50180611	ATHERECTOMY/PTCA LD	92924	480	18081.00	35968.46
50180876	ATHERECTOMY/PTCA LM	92924	480	18081.00	35968.46
50180637	ATHERECTOMY/PTCA RC	92924	480	18081.00	35968.46
50180868	ATHERECTOMY/PTCA RI	92924	480	18081.00	35968.46
50180652	ATHERECTOMY/PTCA ADD LC	92925	480	12455.00	35968.46
50180884	ATHERECTOMY/PTCA ADD LD	92925	480	12455.00	35968.46
50180660	ATHERECTOMY/PTCA ADD RC	92925	480	12455.00	35968.46
50180645	ATHERECTOMY/PTCA ADD RI	92925	480	12455.00	35968.46
50180686	DRUG ELUTING STENT/PTCA LC	92928	480	22376.00	28557.91
50180678	DRUG ELUTING STENT/PTCA LD	92928	480	22376.00	28557.91
50180892	DRUG ELUTING STENT/PTCA LM	92928	480	22376.00	28557.91
50180694	DRUG ELUTING STENT/PTCA RC	92928	480	22376.00	28557.91
50180900	DRUG ELUTING STENT/PTCA RI	92928	480	22376.00	28557.91
50180934	STENT/PTCA LC	92928	480	14796.00	28557.91
50180918	STENT/PTCA LD	92928	480	14796.00	28557.91
50180926	STENT/PTCA LM	92928	480	14796.00	28557.91
50180959	STENT/PTCA RC	92928	480	14796.00	28557.91
50180942	STENT/PTCA RI	92928	480	14796.00	28557.91
50180991	DES/PTCA ADD LC VESSEL/BRNCH	92929	480	13503.00	28557.91
50180967	DES/PTCA ADD LD VESSEL/BRNCH	92929	480	13503.00	28557.91
50180983	DES/PTCA ADD RC VESSEL/BRNCH	92929	480	13503.00	28557.91
50180975	DES/PTCA ADD RI VESSEL/BRNCH	92929	480	13503.00	28557.91
50180728	STENT /PTCA ADD RCVESSEL/BRNCH	92929	480	11511.00	28557.91
50180702	STENT /PTCA ADD RI VESSEL/BRNC	92929	480	11511.00	28557.91
50180710	STENT/PTCA ADD LC VESSEL/BRNCH	92929	480	11511.00	28557.91
50181007	STENT/PTCA ADD LD VESSEL/BRNCH	92929	480	11511.00	28557.91
50181064	ATHERECT/DES/PTCA LC	92933	480	27642.00	28557.91
50181031	ATHERECT/DES/PTCA LD	92933	480	27642.00	28557.91
50181072	ATHERECT/DES/PTCA LM	92933	480	27642.00	28557.91
50181049	ATHERECT/DES/PTCA RC	92933	480	27642.00	28557.91
50181056	ATHERECT/DES/PTCA RI	92933	480	27642.00	28557.91
50180744	ATHERECT/PTCA/STENT LC	92933	480	19951.00	28557.91
50180736	ATHERECT/PTCA/STENT LD	92933	480	19951.00	28557.91
50181023	ATHERECT/PTCA/STENT LM	92933	480	19951.00	28557.91
50180751	ATHERECT/PTCA/STENT RC	92933	480	19951.00	28557.91
50181015	ATHERECT/PTCA/STENT RI	92933	480	19951.00	28557.91
50181106	ATHERECT//PTCA/STENT ADD LC	92934	480	16666.00	28557.91
50181114	ATHERECT//PTCA/STENT ADD LD	92934	480	16666.00	28557.91
50181080	ATHERECT//PTCA/STENT ADD RC	92934	480	16666.00	28557.91
50180777	ATHERECT/DES/PTCA ADD LC	92934	480	17026.00	28557.91
50180769	ATHERECT/DES/PTCA ADD LD	92934	480	17026.00	28557.91
50181122	ATHERECT/DES/PTCA ADD RC	92934	480	17026.00	28557.91
50180785	ATHERECT/DES/PTCA ADD RI	92934	480	17026.00	28557.91
50181098	ATHERECT/PTCA/STENT ADD RI	92934	480	16666.00	28557.91
50181171	ATHERECT/DES/PTCA GRAFT	92937	480	27642.00	28557.91
50180793	ATHERECT/STENT/PTCA GRAFT	92937	480	19951.00	28557.91
50180801	ATHERECT/DES/PTCA ADD GRAFT	92938	480	17026.00	28557.91
50181130	ATHERECT/STENT/PTCA ADD GRAFT	92938	480	16666.00	28557.91
50181148	ATHERECT/DES/PTCA AMI	92941	480	27642.00	28557.91
50180819	ATHERECT/STENT/PTCA AMI	92941	480	19951.00	28557.91
50180827	ATHERECT/DES/PTCA CTO	92943	480	27642.00	28557.91
50181155	ATHERECT/STENT/PTCA CTO	92943	480	19951.00	28557.91

24.) Section C, Economic Feasibility, Question 7.

Please respond to this question specific to the proposed cardiac catheterization service.

Response

As illustrated by the comparison in the previous question, the cardiac catheterization charges for *Erlanger East Hospital* are generally less than those for *Dyersburg Regional Medical Center*. This demonstrates Erlanger's commitment to keep costs as low as is feasible. Pertaining to the volume aspect of the question, the cost to operate the catheterization laboratory at *Erlanger East Hospital* will be generally less than *Erlanger Medical Center* because only pre-screened, low risk cardiac patients will be served. The Projected Data Chart illustrates that the catheterization laboratory at *Erlanger East Hospital* will financially feasible with a positive bet income beginning in year 1.

25.) Section C, Economic Feasibility, Item 9.

Please indicate the percentage of total project revenue anticipated from each of TennCare/Medicaid or other state and federal sources for the proposal's first year of operation.

Please indicate how medically indigent patients will be served by the project.

Response

Anticipated revenue (gross charges) from Federal and State sources during year 1 of the project, is as follows.

	Revenue	% Of Total Revenue
Medicare	$ 526,694	11.6%
TennCare	$ 25,727	0.6%
	$ 552,420	12.2%

26.) Section C, Contribution To Orderly Development, Item 1.

Please clarify if the applicant plans to have any transfer agreements outside of the Erlanger Health System. If so, please list.

Response

Erlanger Health System does not currently plan to have transfer agreements with outside providers of cardiac catheterization services.

27.) Section C, Contribution To Orderly Development, Item 1.

The applicant is projecting 127 and 132 interventional catheterizations in Year One and Year Two that would otherwise be served by another provider. Please describe the effect this proposal will have on the interventional catheterization utilization for providers in the proposed service area.

How will this proposal impact interventional catheterization utilization at Erlanger Hospital?

Response

It is not anticipated that this project will have an impact on the cardiac catheterizations at *Erlanger Medical Center*. The number of interventional catheterizations for *Memorial Hospital* and *Parkridge Medical Center* may decrease slightly. Additionally, some of the decrease for the other catheterization providers may include some of the vulnerable population from East Hamilton County and Bradley County.

28.) Section C, Contribution To Orderly Development, Item 3 - Staffing.

Please provide the current and proposed staffing pattern by completing the following:

Position Title	Current FTEs	Proposed FTEs	Net Change

	Existing Cardiac Diagnostic Cath	for Proposed Cardiac Therapeutic Cath	
Total			

Response

Please note that the cardiac catheterization laboratory is not yet in operation, therefore, the number of existing personnel at that location is zero. As requested, the table is below.

Position Title	Current FTEs Existing Cardiac Diagnostic Cath	Proposed FTEs for Proposed Cardiac Therapeutic Cath	Net Change
Cardiac Specialist	0	4	+4
Total	0	4	+4

29.) Section C, Contribution To Orderly Development, Items 8 and 9.

It is noted the applicant operates as part of the Chattanooga-Hamilton County Hospital Authority. However, please address the following:

Item 8 - Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against Erlanger Hospital and/or Erlanger East Medical Center.

Item 9 - Identify and explain any final civil or criminal judgments for fraud or theft against Erlanger Hospital and/or Erlanger East Medical Center.

Response

As requested, these items are addressed below.

Item 8

There have been no final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any

entities or persons with more than a 5% ownership interest in the applicant.

Item 9

There have been no final civil or criminal judgments for fraud or theft against the applicant, which includes any person or entity with more than a 5% ownership interest in the project.

SUPPLEMENTAL- 1

February 25, 2015
11:30am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger East Hospital

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 24 of February (Month), 2015 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SUPPLEMENTAL- 1

February 25, 2015
11:30am

TABLE OF ATTACHMENTS

SUPPLEMENTAL- 1

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** NOTE - The attachments are paginated and the page number begins with "A". The page number appears in the upper right hand corner of the page.

SUPPLEMENTAL- 1

February 25, 2015
11:30am

ATTACHMENTS

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Licensed Beds	*(*) CON Beds*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical	12	44	12		56
B.	Surgical	6	22	6		28
C.	Long-Term Care Hospital					
D.	Obstetrical	25		25		25
E.	ICU / CCU		4			4
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child / Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (Non – Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid / Medicare)					
P.	ICF / MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	43	70	43		113

(*) CON Beds approved but not yet in service.

Notes

(1) *Erlanger East Hospital* also holds a CON for the transfer of up to 79 additional beds from *Erlanger Medical Center* (no. CN0405-047AE). Nine (9) beds have already been implemented in this process.

(2) *Erlanger East Hospital* also received a CON to transfer six (6) beds from *Erlanger Medical Center* (no. CN0407-067A).

(3) *Erlanger East Hospital* operates as a satellite facility of *Erlanger Medical Center* under the Tennessee Dept. of Health - License No. 000140.

10. Medicare Provider Number 044-0104

network. *Erlanger* is the low cost and safety net provider in the regional service area and participates in narrow networks to facilitate needed care for those who would otherwise not access to needed healthcare services.

Erlanger currently has contracts with the following entities.

A. TennCare Managed Care Organizations

-- BlueCare
-- TennCare *Select*
-- AmeriGroup Community Care
-- United Healthcare

B. Georgia Medicaid Managed Care Organizations

-- AmeriGroup Community Care
-- Peach State Health Plan
-- WellCare Of Georgia

C. Commercial Managed Care Organizations

-- Blue Cross / Blue Shield of Tennessee
  - Blue Network P
  - Blue Network S
  - Blue Network E
  - Blue CoverTN
  - Cover Kids
  - AccessTN
  - Blue Advantage
-- Blue Cross of Georgia (HMO & Indemnity)
-- Bluegrass Family Health, Inc.
  (includes Signature Health Alliance)
-- CIGNA Healthcare of Tennessee, Inc.
  (includes LocalPlus)
-- CIGNA Lifesource (Transplant Network)
-- UNITED Healthcare of Tennessee, Inc.
  (Commercial & Medicare Advantage)
-- Aetna Health
-- Health Value Management D/B/A Choice Care Network (Commercial & Medicare Advantage)
-- HUMANA
  (Choicecare Network, HMO, PPO, POS & Medicare Advantage)
-- HUMANA Military
-- Community Health Alliance
-- HealthSpring (Commercial & Medicare Advantage)

SUPPLEMENTAL- 1
A – 3

February 25, 2015
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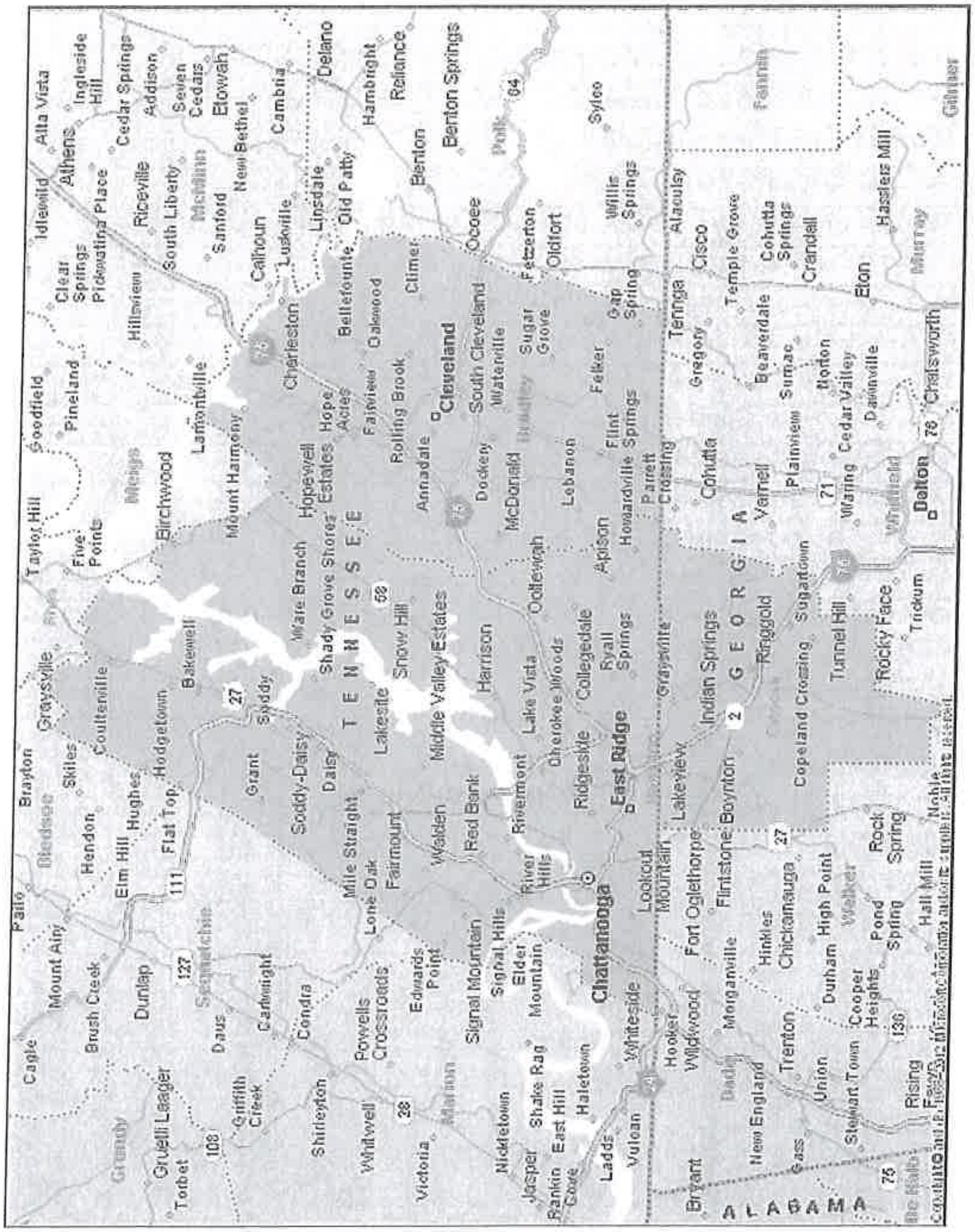
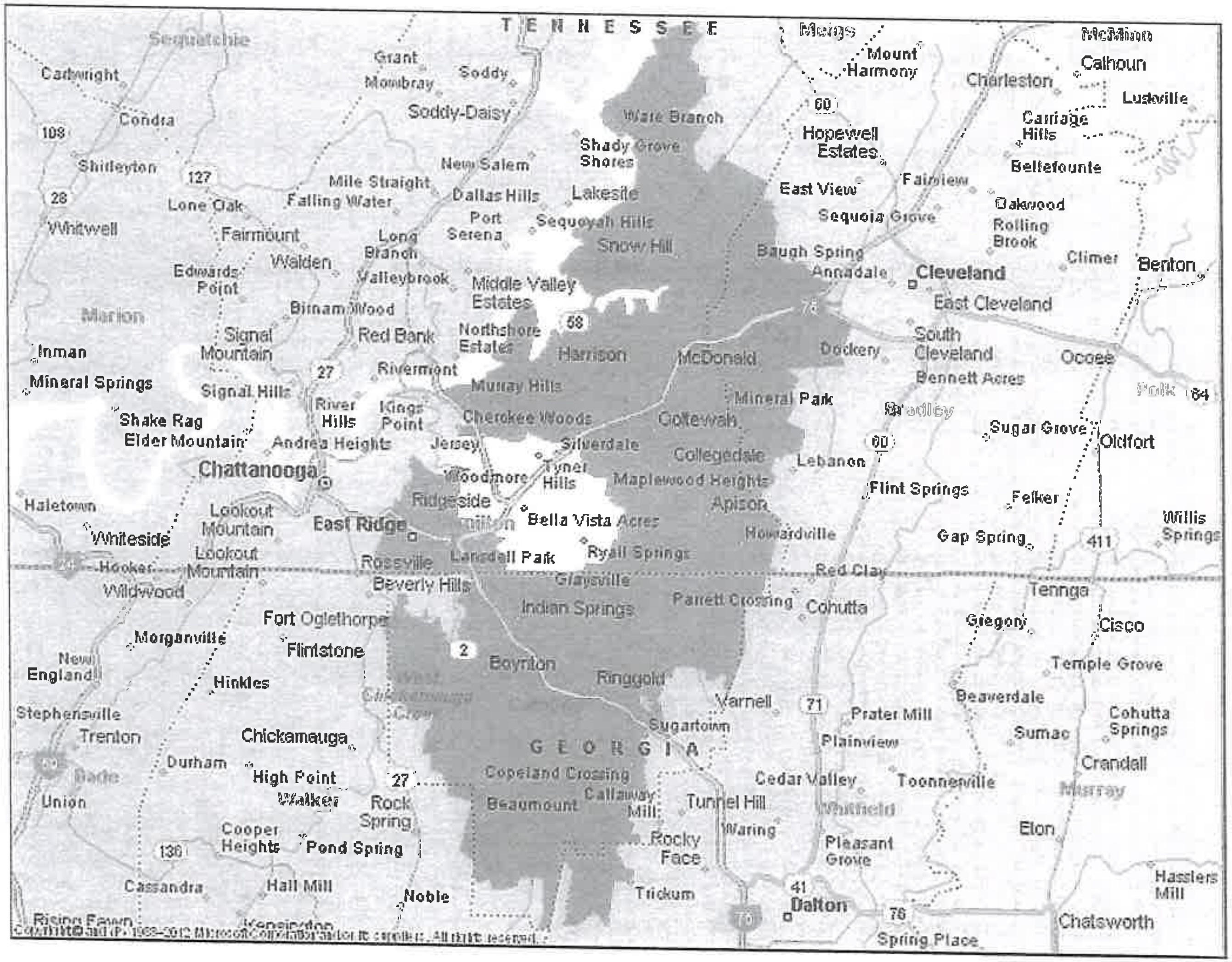
Erlanger East Hospital – Service Area Counties



Erlanger East Hospital – Service Area

10 Zip Codes



** NOTE -- Zip Code in white is 37421, the zip code in which Erlanger East Hospital is located.

SUPPLEMENTAL- 1

A-4

February 25, 2015
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SUPPLEMENTAL 1

February 25, 2015
11:30am

PROJECT COST CHART

A. Construction And Equipment Acquired By Purchase.

1.	Architecural And Engineering Fees	
2.	Legal, Administrative, Consultant Fees (Excluding CON Filing Fees)	
3.	Acquisition Of Site	
4.	Preparation Of Site	
5.	Construction Costs	
6.	Contingency Fund	
7.	Fixed Equipment (Not Included In Construction Contract)	
8.	Moveable Equipment (List all equipment over $ 50,000)	300,000
9.	Other (Specify) _____	

B. Acquisition By Gift, Donation, Or Lease.

1.	Facility (inclusive of building and land)	
2.	Building Only	
3.	Land Only	
4.	Equipment (Specify) _____	
5.	Other (Specify) _____	

C. Financing Costs And Fees.

1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve For One Year's Debt Service	
4.	Other (Specify) _____	

D.	Estimated Project Cost	(A + B + C)	300,000
E.	CON Filing Fee		3,000
F.	Total Estimated Project Cost	(D + E)	303,000

Erlanger Health System -- Other Expenses

	2012	2013	2014
Purchased Services	102,702,749	111,584,374	114,459,641
Utilities	9,757,309	9,736,115	10,012,328
Drugs	32,551,755	32,921,513	39,370,552
Insurance and Taxes	4,467,158	2,198,654	2,723,124
Purchased Services	102,702,749	111,584,374	114,459,641
620142 Restricted Fund Expense	237,126	76,633	117,502
620252 Physician Fees	20,113,740	20,510,257	20,661,564
620302 Consulting	1,668,100	8,018,102	1,421,495
620322 Legal Fees	1,869,626	2,393,527	3,057,657
620332 Audit Fees	211,360	194,406	189,312
620352 Architect & Eng Fees	123,174	182,585	360,654
620492 Time & Mat Contract	3,659,430	3,023,421	4,101,893
620502 Dietary	516,296	621,402	685,028
620522 Unscheduled Maint	3,374,335	4,687,799	5,182,758
620010 Plz Surgery Minority Interesy	-149,843		
620523 CUC Delivery/Vehicle Expense	31,248	32,607	17,732
620532 Advertising	2,198,138	2,555,479	2,490,627
620542 Purchased Services	31,214,122	29,055,253	31,846,157
620562 Purchased Maint	3,908,269	3,220,291	4,115,060
620572 Freight Charges	275,027	314,512	293,794
620573 CUC Penalties	2,561	1,425	
620574 CUC Late Fees	2,000	4,971	7,378
620582 Collection Fees	162,324	738,913	904,813
620602 Lab Outside Fees	3,709,926	3,205,690	3,257,673
620622 Computer Services	4,501,692	4,970,519	5,156,385
620682 Micro Maint	95,567	74,128	60,533
620692 Equipment Rental	3,246,154	3,033,690	3,605,722
620792 Contracted Services	15,797,297	18,663,071	20,802,740
620892 Membership & Dues	1,398,184	1,167,871	948,989
620902 Special Classes	10,365	27,957	45,251
620912 Licenses & Fees	1,175,538	1,281,524	1,379,705
620922 Development Costs	45,716	176,338	406,179
620932 Professional Education	1,059,982	1,045,961	1,161,763
620933 CUC Meals & Entertainment	9,910	11,491	1,291
620952 Local Travel	315,197	323,282	287,345
620953 CUC Field Trip Expense	9,764	12,657	23,799
620982 Business Courtesy	34,226	44,274	13,444
621182 Asbestos Expense	31,350	128,761	63,639
621202 Recruiting	634,222	670,202	824,569
621272 Resident Education	311,609	295,055	295,284
621532 Public Relations	474,619	487,507	271,427
621972 Patient parking	186,556	217,813	213,034
622002 Med/Prof Housing Expense	237,841	115,000	187,444
Utilities	9,757,309	9,736,115	10,012,328
640702 Billed Utilities	-412,326	-461,257	-576,458
640712 Electricity	6,111,788	5,927,593	6,124,308
640722 Gas	1,552,861	1,559,592	1,848,971
640732 Water	1,050,175	1,136,971	1,195,584
640742 Oil	10,816	6,450	19,507
640752 Storm Water Fees	53,048	39,551	43,267
640882 Telephone	1,390,947	1,527,215	1,357,149
Drugs	32,551,755	32,921,513	39,370,552
630403 Drugs	32,551,755	32,921,513	39,370,552
Insurance and Taxes	4,467,158	2,198,654	2,723,124
670847 Self Insurance Expense	1,686,257	952,825	704,755
670857 Insurance	2,695,711	1,207,188	1,971,569
680878 CUC Taxes - Sales	11,966	629	178
680880 Gross Receipts Tax	73,224	38,012	46,622

SUPPLEMENTAL- 1
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Projected Data Chart -- Other Expenses

	Year 1	Year 2
EHS Clinical Engineering - Maintenance	43,990	49,600
Allocation For Service Contracts	17,804	20,074
Allocation For Miscellaneous Expenses	13,655	15,396
Total	75,449	85,070

February 25, 2015
11:30am

John V. Golding, III, M.D.

PERSONAL

U.S. Citizen

CURRENT POSITION

Interventional Cardiology, UT Erlanger Cardiology - East
1614 Gunbarrel Road, Suite 101 Chattanooga, TN 37421

Medical Director - Erlanger Cath lab March 2011- present

TRAINING & PRACTISE

2006 - 2010 Interventional Cardiologist, Cardiovascular Care Ctr.
Director of Nuclear Cardiology
1614 Gunbarrel Road, Suite 101 Chattanooga, TN 37421

2004 - 2006 Cardiologist, Galen Medical Group
Erlanger Medical Center - 979 East 3rd Street Suite C- 520

July 1997 – June 1998
Internal Medicine at Washington Hospital Center
Washington, DC
Internship

July 1998 – June 2000
Internal Medicine at Washington Hospital Center
Washington, DC
Residency

July 2000 – June 2003
Brown University, Miriam Hospital
Providence, RI
Fellowship: Cardiology

July 2003 – June 2004
Brown University, Miriam Hospital
Providence, RI
Fellowship: Interventional Cardiology

LEVEL 2 in TTE
LEVEL 3 in TEE
LEVEL 2 in Nuclear Cardiology
LEVEL 3 in Cardiac Cath

EDUCATION

May 1997 – Doctor of Medicine
Meharry Medical College – Nashville, TN

1993 - B.S. Chemistry
Howard University - Washington, DC

MEDICAL LICENSURE & CERTIFICATIONS

State of Tennessee (MD0000021693) 2004

State of Georgia, License No: 63590
Issued: November 5th 2009

The American Board of Internal Medicine
2000

The American Board of Internal Medicine
Cardiovascular Disease
2003 - 2013

The Certification Board of Nuclear Cardiology
2004 – 2014

The American Board of Internal Medicine
Interventional Cardiology
2004 - 2014

PROFESSIONAL MEMBERSHIPS

American College of Cardiology

American Heart Association

Association of Black Cardiologist

National Medical Association

HONORS AND AWARDS RECIEVED

ABC/Guidant/ 4th year Interventional Cardiology Scholarship

The Edmond F. Noel, Sr., MD award

The John H. Walls, MD Endowed Scholarship Fund

Meharry Medical College Academic Scholarship

Dean's list 1993-1994

AT&T Scholarship

CURRICULUM VITAE

Walter Lee Few, III, M.D., F|A.C.C.

Cardiovascular Care Center, PLLC
1614 Gunbarrel Road, Suite 101
Chattanooga, TN 37421
(423) 553-7600 Work
(423) 826-8609 Fax

Education

1. Emory University School of Medicine, Emory University Hospital, Suite F 606, 1364 Clifton Road, N.E., Atlanta, GA 30322. Interventional Cardiology Fellowship. Program Director: Ziyad Ghazzal, M.D. July 2004 – June 2005.

2. Emory University School of Medicine, 1639 Pierce Drive, 319 WMB, Atlanta, GA 30322. Cardiology Fellowship. Program Directors: W. Robert Taylor, M.D., Ph.D. and Maziar Zafari, M.D., Ph.D. July 2001 – June 2004.

3. Emory University School of Medicine, 69 Jesse Hill Jr. Drive, S.E., Atlanta, GA 30303. Internal Medicine Internship and Categorical Residency. Program Director: Joyce Doyle, M.D. July 1997 – June 2000.

4. Johns Hopkins University School of Medicine, 720 Rutland Avenue, Baltimore, MD 21205. Medical School, August 1993 – May 1997, M.D. degree conferred.

5. Morehouse College, 830 Westview Drive, S.W., Atlanta, GA 30314. Undergraduate School, August 1989 – May 1993, Major in Biology with a Minor in Psychology, Summa cum laude, B.S. degree conferred.

Professional Experience

Hospital Admissions Services, L.L.C., Internal Medicine Attending, Crawford Long Hospital of Emory University, 478 Peachtree Street, N.E., Suite 106-A, Atlanta, GA 30308-3124. Manager: Jacinto Del Mazo, M.D. July 2000 – June 2001.

Galen Medical Group, Interventional Cardiology and Peripheral Vascular Disease, 979 East Third Street, Erlanger Plaza, Suite C520, Chattanooga, TN 37403. Director: Walter Parkhurst, M.D. October 2005 – June 2006

Cardiovascular Care Center, PLLC, Interventional Cardiology and Peripheral Vascular Disease, 1614 Gunbarrel Road, Suite 101, Chattanooga, TN 37421. President: Michael Love, M.D. July 2006 – Current.

Professional Staff

Memorial Health Care System, Inc. 2525 de Sales Avenue, Chattanooga, TN 37404-1102. Phone (423) 495-2525. October 2005 – Current.
Parkridge Medical Center, 2333 McCallie Avenue, Chattanooga, TN 37404. Phone (423) 698-6061. October 2005 – Current.
Erlanger Medical Center, 975 East Third Street, Chattanooga, TN 37403. Phone (423) 778-7000. October 2005 – Current.

Licensure

State of Georgia Medical Board Physician, 1998 – Current, Number 046092.
State of Tennessee Medical License, 2005 – Current, Number 40120.
Diplomate of the American Board of Internal Medicine, exam taken August 22-23, 2000, certified for 2000-2010.
Diplomate of the American Board of Internal Medicine in Cardiovascular Disease, exam taken November 3-4, 2004, certified for 2004-2014.
Diplomate of the American Board of Internal Medicine in Interventional Cardiology, exam taken November 9, 2006, certified for 2006-2016.

Honors

Phi Beta Kappa, 1992
Beta Kappa Chi Scientific Honor Society, 1992
Golden Key National Honor Society, 1992
Louis W. Sullivan Pre-medical Scholar Award, Morehouse College, 1993
Valedictorian, Morehouse College, 1993
Frederick E. Mapp Prize in Biology, Morehouse College, 1993
Samuel Milton Nabrit Award, Morehouse College, 1993
Anafred N. Halpern New Investigator Award, American College of Nutrition, 1995
Research Grant, American Heart Association, July 2003 – June 2005
Chief Interventional Cardiology Fellow, Emory University School of Medicine, July 2004 – June 2005
Fellow of the American College of Cardiology, elected September 1, 2008

Research

1991 Oxygen consumption in turtle ventricular myocytes. Department of Comparative Physiology, Brown University, Providence, RI.
Preceptors: Donald C. Jackson, Ph.D., Cheryl L. Watson, Ph.D.

1992 Effects of anoxia on glucose uptake by turtle skeletal and cardiac muscle. Department of Comparative Physiology, Brown University, Providence, RI. Preceptors: Donald C. Jackson, Ph.D., Cheryl L. Watson, Ph.D.

1994 Weight loss in HIV infection and its relationship to serum hormones. Department of Endocrinology and Metabolism, Johns Hopkins University School of Medicine, Baltimore, MD. Preceptor: Adrian S. Dobs, M.D. M.H.S.

July 2003-June 2005 The effect of progenitor cell mobilization using colony stimulating factors in myocardial infarction. Division of Cardiology, Emory University School of Medicine, Atlanta, GA. Principle Investigator: Arshed Quyyumi, M.D. Co-Investigator: Walter L. Few, III, M.D. Supported by grant from the American Heart Association (July 2003-June 2005) and Berlex.

July 2003-June 2004 Physiologic and pathologic role of endothelium-derived hyperpolarizing factor in humans. Division of Cardiology, Emory University School of Medicine, Atlanta, GA. Principle Investigator: Arshed Quyyumi, M.D. Co-Investigators: W. Lance Lewis, Walter L. Few, III, M.D., Veerappan Subramaniyam.

Publications

1. Watson CL, Few III WL, Panol G, Jackson DC. Lactic acidosis transiently increases metabolic rate of turtle myocytes. American Journal of Physiology, 266(4 Pt 2):R1238-1243, 1994, April.94241302

2. Dobs AS, Few III WL, Blackman MR, Harman SM, Hoover DR, Graham NMH. Serum hormones in men with HIV-associated wasting. Journal of Clinical Endocrinology and Metabolism, 81(11) 4108-12, 1996, Nov.97082632

3. Few W, Block P, Ghazzal Z. Cath case of the month, December 2002. American College of Cardiology Website: www.acc.org.

Societies and Memberships

Morehouse Alumni Association
American College of Cardiology
Society of Cardiovascular Angiography and Interventions

References

1. W. Robert Taylor, M.D., Ph.D., Program Director of Emory Cardiology Fellowship. 1639 Pierce Drive, Suite 319 WMB, Atlanta, GA 30322. (404) 727-4724. E-mail: wtaylor@emory.edu.

2. Arshed Quyyumi, M.D. Emory University Hospital, 1364 Clifton Road, N.E., Suite F606, Atlanta, GA 30322. (404) 727-3655. E-mail: aquyyum@emory.edu.

3. John Douglas, M.D. Director of Interventional Cardiology Fellowship Training Program, Emory University Hospital, 1364 Clifton Road, N.E., Suite F606, Atlanta, GA 30322. (404) 712-7424.

4. Henry Liberman, M.D. The Emory Clinic Crawford Long, 550 Peachtree Street, N.E., Medical Office Tower 6th Floor, Atlanta, GA 30308. (404) 686-2503. E-mail: henry_liberman@emoryhealthcare.org

5. Michael Love, M.D. Cardiovascular Care Center, PLLC. 1614 Gunbarrel Road, Suite 101, Chattanooga, TN 37421. (423) 553-7600. E-mail: mlove@ccctn.net

6. D. Christopher Metzger, M.D. The Heart Center. 2050 MeadowView Parkway, Kingsport, TN 37660. (423) 230-5000.

SUPPLEMENTAL- 1
A – 14
February 25, 2015
11:30am

CURRICULUM VITAE
John Carter Hemphill, M.D.

CURRENT POSITION

2009-Present	Interventional and General Cardiology Augusta Cardiology Clinic, P.C.	Augusta, GA

GRADUATE MEDICAL EDUCATION

2008-2009	Texas A&M College of Medicine/Scott & White Hospital *Interventional Cardiology Fellowship*	Temple, TX
2005- 2008	University of Texas Health Science Center *Cardiovascular Disease Fellowship*	San Antonio, TX
2002-2005	University of Texas Health Science Center *Internal Medicine Residency*	San Antonio, TX
2001-2002	Boston University Medical Center/Brockton Hospital *Transitional Year Residency*	Boston/Brockton, MA

EDUCATION

1997 – 2001	University of South Carolina School of Medicine *Doctor of Medicine*	Columbia, SC
1993 – 1997	Columbia University *Bachelor of Arts, Economics* Dean's List 1994 – 1997	New York, NY

LICENSURE AND CERTIFICATION

2009-2019	Interventional Cardiology Board Certified
2008-2018	Cardiovascular Diseases Board Certified
2009	American Board of Vascular Medicine: Diplomate in Endovascular Medicine
2008	Certification Board of Nuclear Cardiology: Diplomate
2005-2015	Internal Medicine Board Certified
2009-Present	Georgia Composite Medical Board License Number 62856
2005-Present	Texas State Board Medical License Number M1137
Through 11/2011	ACLS/BCLS Certified

CURRICULUM VITAE – PAGE 2
John Carter Hemphill, M.D.

PUBLICATIONS AND RESEARCH

2007	Beaudry D, Stone K, Wetherold S, Hemphill J, Do D, McClish J, Chilton R. Statin therapy in cardiovascular diseases other than atherosclerosis. Current Atherosclerosis Reports. 2007;9(1):25-32.	
2006-Present	N-acetylcysteine and sodium bicarbonate versus hydration with normal saline for the prevention of contrast-induced nephropathy in patients undergoing cardiac catheterization. Ongoing research: UTHSCSA IRB ID: Pro00000689 Principal Investigator: Steven R. Bailey Co-Investigator: John Carter Hemphill	San Antonio, TX
2003-2004	Research Associate, Angiogenesis Trial Phase 2B/3 (A Multicenter, Randomized, Double-Blind, Placebo Controlled Study to Evaluate the Efficacy and Safety of Ad5.1 FGF-4 in Patients with Stable Angina)	San Antonio, TX
Summer 1996	Research Fellow, Center for Neurobiology and Behavior of Columbia University (participated in research involving the inhibitor to the cAMP dependent protein kinase)	New York, NY

AWARDS AND EXTRACURRICULAR ACTIVITIES

2004	Poster presentation finalist, American College of Physicians, South Texas Chapter Clinical Conference	San Antonio, TX
2003 – 2004	MSRDP Resident Advisory Committee Representative for the Department of Internal Medicine	San Antonio, TX

TEACHING EXPERIENCE

2005-2008	University of Texas Health Science Center at San Antonio Division of Cardiology Auscultation Class, Preceptor (taught second year medical students cardiac auscultation skills)	San Antonio, TX
2005	University of Texas Health Science Center at San Antonio Divison of Cardiology Electrocardiography Class, Preceptor (taught second year medical students basic electrocardiography)	San Antonio, TX
2003-2005	University of Texas Health Science Center at San Antonio Department of Internal Medicine Advanced Clinical Examinations Skills, Preceptor (taught second year medical students to perform and present the medical history and physical examination)	San Antonio, TX

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11:30am

CURRICULUM VITAE – PAGE 3
John Carter Hemphill, M.D.

VOLUNTEER EXPERIENCE

February, 2001	Medical Mission Volunteer (provided free medical care to needy communities)	Nicaragua
1995-1996	Emergency Room Volunteer St. Luke's/Roosevelt Hospital	New York, NY

PROFESSIONAL MEMBERSHIPS

American College of Cardiology

American Medical Association

PERSONAL

Private Pilot, Conversational in Spanish, limited HTML, CSS, PHP coding abilities

Hobbies: wakeboarding/snowboarding/skiing, auto restoration, piano, guitar

REFERENCES

Steven Bailey, M.D.
Professor of Medicine & Radiology
Chief, Division of Cardiology
University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive, MC 7872; San Antonio, TX 78229
(210) 567-4600

Gregory J. Dehmer, M.D.
Professor of Medicine
Director, Division of Cardiology
Texas A&M Health Science Center College of Medicine/Scott & White
Scott & White Memorial Hospital
2401 South 31st Street; Temple, Texas 76508
(254) 724-6782

CURRICULUM VITAE – PAGE 4
John Carter Hemphill, M.D.

REFERENCES (continued)

John M Erikson, M.D., Ph.D.
Associate Professor of Medicine, Division of Cardiology;
Program Director, Cardiovascular Disease Fellowship Program
University of Texas Health Science Center at San Antonio

David Scott Gantt, D.O.
Professor of Internal Medicine
Chief, Section of Interventional Cardiology
Program Director, Cardiovascular Disease Fellowship Program
Texas A&M Health Science Center College of Medicine/Scott&White Memorial Hospital
2401 South 31st Street
Temple, TX 76508
(254) 724-2491

Debra Hunt, M.D., M.S.P.H.
Department of Internal Medicine, Residency Program Director
University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive, MC 7871; San Antonio, TX 78229
(210) 567-4820

David McCall, M.D., Ph.D.
Professor of Medicine, Division of Cardiology;
Director, Coronary Care Unit
University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive, MC 7872; San Antonio, TX 78229
(210) 567-4600

Devang Patel, M.B. Ch.B.
Program Director, Interventional Cardiology Fellowship Program
Assistant Professor of Medicine, Division of Cardiology
University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive, MC 7872; San Antonio, TX 78229
(210) 567-4600

February 25, 2015
11:30am

Robert L. Huang, MD MPH

Date of Birth:	03/09/1976
Marital status:	Married
Business Address:	Erlanger Health System 975 E. Third Street Chattanooga, TN 37403
Business Phone:	(423) 778-5661
E-mail:	robert.huang@erlanger.org; robhuang7@hotmail.com

EDUCATION:

8/1994-8/1998	Case Western Reserve University School of Engineering Cleveland, OH B.S. in Biomedical Engineering *Magna Cum Laude*
8/1998-6/2002	Case Western Reserve University School of Medicine Cleveland, OH Doctor of Medicine
7/2005-5/2007	Vanderbilt University Medical Center Nashville, TN Masters of Public Health

TRAINING:

7/2002-6/2005	Vanderbilt University Medical Center Nashville, TN Internal Medicine Residency
7/2005-6/2007	VA Quality Scholars Fellowship Nashville, TN
7/2007-6/2010	Vanderbilt University Medical Center Nashville, TN Cardiovascular Medicine Fellowship Chief Fellow
7/2010-6/2011	Vanderbilt University Medical Center Nashville, TN Interventional Cardiology Fellowship

LICENSURE/CERTIFICATION:

USMLE Step 1	June 2000
USMLE Step 2	September 2001
USMLE Step 3	December 2003
Tennessee Medical License	Since March 2004
American Board of Internal Medicine (ABIM)	August 2005
ABIM – Cardiovascular Diseases	November 2010
ABIM – Interventional Cardiology	October 2011
ACLS/BLS	Since 2002
Georgia Medical License	September 2011

ACADEMIC APPOINTMENTS:

UT College of Medicine - Chattanooga, Clinical Assistant Professor
Vanderbilt University Medical Center Volunteer Faculty Appointment, Division of Cardiovascular Medicine

HOSPITAL APPOINTMENTS:

Erlanger Health System – General and Interventional Cardiology
Erlanger Health System – Planning Committee, Board of Trustees

PROFESSIONAL ORGANIZATIONS:

AHA – American Heart Association
ABIM – American Board of Internal Medicine
ACC – American College of Cardiology
SCAI – Society for Cardiac Angiography and Interventions

PROFESSIONAL ACTIVITIES:

Section Editor for the *Journal of Clinical Outcomes Management*
Reviewer for *Quality and Safety in Health Care*
Reviewer for *Journal of Invasive Cardiology*
Reviewer for *Nature Clinical Practice Cardiology*
Reviewer for *American Heart Journal*

INSTITUTIONAL SERVICE (Committees, Councils, Task Forces)

UT-Erlanger Cardiology Recruitment Committee Chair
Implemented QI Curriculum for Cardiology Fellowship
Vanderbilt Page-Campbell Moonlighting Coordinator
Vanderbilt CCU Moonlighting Coordinator
Vanderbilt Heart and Vascular Institute Operations Council
Vanderbilt Heart and Vascular Institute Quality Council

Vanderbilt Heart and Vascular Institute Curriculum Committee
Vanderbilt University Medical Center STEMI Network Committee
Vanderbilt University Medical Center Chest Pain Committee
VA Hypertension Quality Improvement Task-Force for VISN 9
Tennessee AHA Cardiac Systems of Care Task-Force
STEMI Council Erlanger Health System

TEACHING:

Chief Fellow in Cardiology
Physical Diagnosis Instructor, Evaluator
Inpatient Ward Attending
VA Triage Attending
Preceptor for Internal Medicine Journal Club
Research mentor/supervisor
- Eric Thomassee, MD – current cardiovascular medicine fellow at VUMC
- Jae Yoon Park, MD – current internal medicine resident at Mayo Clinic

Regularly supervises internal medicine residents on the cardiology consult service

INVITED LECTURES:

1. Huang RL. Therapies for GERD. Vanderbilt Morning Report, 6/2004.

2. Huang RL. The value of PSA and prostate CA therapy. Vanderbilt Morning Report, 10/2004.

3. Huang RL. Evidence behind CABG. Senior Talk, Vanderbilt University Medical Center, 1/2005.

4. Huang RL, Kurtz EG. Appropriateness Criteria of Coronary CT Angiography. Cardiology Journal Club, Vanderbilt University, 2/2008.

5. Huang RL, Kronenberg MW. Medical Therapy of Chronic Stable Angina. Clinical Management Conference, Vanderbilt University, 2/2008.

6. Huang RL, Clair W. Arrhythmogenic Right Ventricular Cardiomyopathy. Clinical Management Conference, Vanderbilt University, 9/29/09.

7. Huang RL. STEMI Outcomes 2009. Cardiology Grand Rounds, Vanderbilt University, 3/2010.

8. Huang RL, Salloum JG. Current STEMI Management. Clnical Management Conference, Vanderbilt University, 2/2011.

PUBLICATIONS

A. ORIGINAL INVESTIGATIONS

1. Huang R, Eisen G. Efficacy, safety, and limitations in current practice of sedation and analgesia. Gastrointest Endosc Clin N Am. 2004 Apr 14(2):269-88.

2. Huang RL, Listerman J, and Butler J. Risk Factors for Heart Failure Progression and Prognosis. Current Cardiology Reviews 2006 May; 2(2): 79-88.

3. Huang RL, Geisberg C, Howser R, Portner Peer, Pierson III RN, Butler J. Effect of age on outcomes after left ventricular assist device placement. Transplantation Proceedings 2006 Jun; 38(5): 1496-1498.

4. Geisberg C, Goring J, Listerman J, Nading MA, Huang RL, Butler J. Impact of optimal heart failure medical therapy on heart transplant listing. Transplant Proc. 2006 Jun; 38(5):1493-5.

5. Giesberg C, Goring J, Huang RL, Listerman J, Nading MA, and Butler, J. Anemia in heart failure may warrant more aggressive listing for cardiac transplantation. Transplant Proc. 2006 Jun; 38(5):1499-500.

6. Huang RL, Listerman J, Goring J, Giesberg C, Nading MA, and Butler, J. β-Blocker Therapy for Heart Failure: Should the Therapeutic Target be Dose or Heart Rate Reduction? Congestive Heart Failure 2006 Jul-Aug; 12(4): 206-210.

7. Listerman J, Huang RL, and Butler J. Risk Factors for Development of Heart Failure. Current Cardiology Reviews 2007. January; 3(1): 1-9.

8. Listerman J, Goring J, Geisberg C, Nading MA, Huang RL, and Butler J. Hemodynamic response and exercise capacity among anemic and non-anemic heart failure patients. Congestive Heart Failure 2007 Mar-Apr; 13(2):71-77.

9. Huang RL, Donelli A, Byrd J, Mickiewicz MA, Slovis C, Elasy TA, Speroff TS, Dittus RS, DiSalvo TG, Zhao D. Using Quality Improvement Methods to Improve Door-to-Balloon Time at an Academic Medical Center. Journal of Invasive Cardiology 2008 Feb; 20(2): 46-52.

10. Huang RL, Crenshaw M. The Impella Device and Other Percutaneous Support Available at Vanderbilt. Vanderbilt Heart and Vascular Institute Spring Newsletter 2009.

11. Choma NN, Huang RL, Dittus RS, Burnham KE, Roumie CL. Quality Improvement Initiatives Improve Hypertension Care Among Veterans. Circ Cardiovasc Qual Outcomes. 2009 July; 2:392-398.

12. Choma NN, Griffin MR, Huang RL, Roumie CL, et al. An Algorithm to Identify Incident Myocardial Infarction Using Medicaid Data. Pharmacoepidemol Drug Saf. 2009 Nov; 18(11):1064-71.

13. Huang RL. Use of Prasugrel in Acute Coronary Syndrome. Vanderbilt STEMI Newsletter, January 2010.

14. Schnipper JL, Roumie CL, Cawthon C, et al. Rationale and Design of the Pharmacist Intervention for Low Literacy in Cardiovascular Disease (PILL-CVD) Study. Circ Cardiovasc Qual Outcomes. 2010; 3:212-219. Adjudicator – medication errors.

15. Reagan BW, Huang RL, Clair WK. Palpitations: an annoyance that may require clairvoyance. Circulation. 2012 Feb 21; 125(7):958-65.

16. Kripalani S, Roumie CL, Dalal AK, Cawthon C, Businger A, Eden SK, Shintani A, Sponsler KC, Harris LJ, Theobald C, Huang RL, Scheurer D, Hunt S, Jacobson TA, Rask KJ, Vaccarino V, Gandhi TK, Bates DW, Williams MV, Schnipper JL; PILL-CVD (Pharmacist Intervention for Low Literacy in Cardiovascular Disease) Study Group. Effect of a pharmacist intervention on clinically important medication errors after hospital discharge: a randomized trial. Ann Intern Med. 2012 Jul 3; 157(1):1-10.

17. Huang RL, Thomassee EJ, Park JY, Scott CR, Maron DJ, Fredi JL. Scene STEMI Protocol to Facilitate Long-Distance Transfer for Primary PCI. Accepted Crtical Pathways in Cardiology to be published December 2012.

B. BOOK CHAPTERS

1. Huang RL, Maron DJ. Hurst's The Heart: Manual of Cardiology, 12th Edition. Chapter 21, Dyslipidemia & Other Cardiovascular Risk Factors, pp 237-260.

C. ABSTRACTS

1. Huang RL, Dillon GP, Bellamkonda R. Three-Dimensional Patterning in Gels for Three-Dimensional Nerve Guidance. Progress report prepared for Whitaker Summer Fellows Program.

2. Huang RL, McCormick TS, Cooper KD. Infiltrating Leukocytes Mediate Reactive Oxygen Species Following UV Radiation. Progress report prepared for American Cancer Society.

3. Huang RL, Goring J, Nading MA, Listerman J, Giesberg C, Khadim G, and Butler J. The Relationship between Renal Function and Left Ventricular Assist Device Use. Journal of Cardiac Failure, 2005; S136

4. Giesberg C, Nading MA, Listerman J, Huang RL, Goring J, Khadim G, and Butler J Varying prognostic implication of peak exercise oxygen consumption in anemic vs. non-anemic patients. Journal of Cardiac Failure, 2005;S168

5. Listerman J, Giesberg C, Nading MA, Huang RL, Goring J, Khadim G, and Butler J Exercise hemodynamics does not explain worse exercise capacity among anemic heart failure patients. Journal of Cardiac Failure, 2005;S104

6. Nading MA, Listerman J, Giesberg C, Huang RL, Goring J, Khadim G, and Butler J. Resting Cardiac Index Correlates Poorly with Renal Function in Heart Failure Patients. Journal of Cardiac Failure, 2005;S105

7. Goring J, Nading MA, Listerman J, Giesberg C, Huang RL, Khadim G, and Butler J. Metabolic Syndrome Predicts a Higher Risk for Heart Failure Hospitalizations in the Elderly. Journal of Cardiac Failure, 2005;S167

8. Huang RL, Byrd J, Speroff T, Dittus R, Elasy TA, DiSalvo T, Slovis C, Mickiewicz M, Zhao D. Door-to-Balloon Time: An Opportunity to Showcase Quality Improvement Methods. Journal of the American College of Cardiology 2007; 49(9): 273A.

9. Huang RL, Byrd, J, Dittus R, Elasy TA, DiSalvo, T, Zhao D, Speroff T. Improving Reliability of Door-to-Balloon Processes with System-Based Interventions. Critical Pathways in Cardiology 2007; 6(3): 135.

10. Huang RL, Byrd, J, Dittus R, Elasy TA, DiSalvo, T, Zhao D, Speroff T. Using Statistical Process Control to Drive Improvement in Door-to-Balloon Time. Journal of General Internal Medicine 2007; Vol 22, Supplement 1: 141.

11. Huang RL, Roumie CL, Elasy TA, Dittus RS, Gaffney FA, Greevy R, DiSalvo, T, Speroff, T. Medically-Treated Transfer Patients with Acute Myocardial Infarction Have Higher In-hospital Mortality than Non-Transferred Patients. Circulation 2007; 115 (21):e550, #97.

12. Choma NN, Huang RL, Dittus RS, Burnham KS, Roumie CL. Local Quality Improvement Initiative Improves Hypertension Care among Veterans. Circulation 2008; 117 (21): e445, #160.

13. Thomassee E, Huang RL, Steaban R, Scott C, Fredi JL. Using Emergency Medical Services on the Scene to Activate the Cardiac Catheterization Laboratory in STEMI Patients. Critical Pathways in Cardiology 2009; 8(3): 135.

14. Huang RL, Thomassee E, Scott CR, Steaban R, Zhao DX, Fredi JL. Transfer STEMI Patients Experience Most Delays in Outlying Hospitals. Circulation Cardiovascular Quality and Outcomes 2009; 2: e1-e66.

15. Kelley MB, Huang RL, Wells QS, Fredi JL, Scott CR, McPherson JA for the Vanderbilt Heart and Vascular Institute , Nashville, TN. Outcomes In Comatose Cardiac Arrest Patients With ST Elevation Myocardial Infarction Treated With Therapeutic Hypothermia And Percutaneous Coronary Intervention. Critical Care Medicine, December 2010, Volume 39, Issue 12, A462.

ORAL PRESENTATIONS:

1. Huang RL. Case Presentation – Scimitar Syndrome. 10th Annual G.C. Fresinger Society Meeting, The Chattanoogan, 4/2009.

2. Huang RL. Case Presentation – Arrhythmogenic Ventricular Cardiomyopathy. 11th Annual G. C. Fresinger Society Meeting, 4/2010.

3. Huang RL, Hoff S, Salloum JG, Glazer MD, Lenihan D, Fredi JL. Coronary Mycotic Aneurysm Closure. i2 Summit 2011 Challenging Cases at ACC, 4/2011. Peer-reviewed.

4. Huang RL, Zhao DX. Challenging Pseudoaneurysm Case, TCT 2011, 11/2011. Peer-reviewed.

POSTER PRESENTATIONS:

1. Huang RL. β-Blocker Therapy for Heart Failure: Should the Therapeutic Target be Dose or Heart Rate Reduction? Vanderbilt University GME Poster Session, 5/2006.

2. Huang RL, Speroff T, Dittus RS, Elasy TA, Roumie CL. Improving Hypertension Quality of Care Using Systems-based Interventions. VA HSR&D, 2/2007.

3. Huang RL, Roumie CL, Elasy TA, Dittus RS, DiSalvo T, Speroff T. Medically-Treated Transfer Patients with Acute Myocardial Infarction Have Higher In-hospital Mortality than Non-Transferred Patients at Vanderbilt University Medical Center. Vanderbilt University GME Poster Session, 5/2007.

4. Huang RL, Donelli A, Byrd J, Mickiewicz MA, Slovis C, Elasy TA, Speroff TS, Dittus RS, DiSalvo TG, Zhao D. Using Quality Improvement Methods to Improve Door-to-Balloon Times at Vanderbilt University Medical Center. Vanderbilt University GME Poster Session, 5/2007.

5. Huang RL, Roumie CL, Elasy TA, Dittus RS, DiSalvo T, Speroff T. Medically-Treated Transfer Patients with Acute Myocardial Infarction Have Higher In-Hospital Mortality than Non-Transferred Patients. 8th AHA Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke 2007.

6. Huang RL, Roumie, CL, Speroff T, Elasy T, DiSalvo, T, Dittus R, Zhao, D, et al. Using Statistical Process Control to Drive Improvement in Door-to-Balloon Time. SGIM 2007 30th Annual Meeting.

7. Huang RL, Byrd J, Speroff T, Elasy T, DiSalvo, T, Dittus R, Zhao, D, et al. Improving Reliability of Door-to-Balloon Processes with System-Based Interventions. Tenth Congress of the Society of Chest Pain Centers 2007.

8. Huang RL, Thomassee E, Steaban R, Scott C, Vaughan D, Zhao DX, Fredi JL. Transfer STEMI Patients Experience Most Delay in Outlying Hospitals. 10th AHA Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke 2009.

9. Thomassee E, Huang RL, Steaban R, Scott C, Fredi JL. Using Emergency Medical Services on the Scene to Activate the Cardiac Catheterization Laboratory in STEMI Patients. Twelfth Congress of the Society of Chest Pain Centers 2009.

10. Huang RL, Cunningham B, Zhao DX, Steaban R, Disalvo TG. Creating and Sustaining a Reliable Door to Balloon Process: The VHVI Experience. 11th AHA Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke 2010.

11. Kelley MB, Huang RL, Wells QS, Fredi JL, Scott CR, McPherson JA for the Vanderbilt Heart and Vascular Institute , Nashville, TN. Outcomes In Comatose Cardiac Arrest Patients With ST Elevation Myocardial Infarction Treated With Therapeutic Hypothermia And Percutaneous Coronary Intervention. Society of Critical Care Medicine January 2011.

February 25, 2015
11:30am

Poonam Puri, MD
Curriculum Vitae

GENERAL INFORMATION:

Name: Poonam Puri
Gender: Female

EDUCATION AND TRAINING:

Jan 2011 - Present — Working part time at Kaiser Permanente, Santa Clara, CA and Santa Clara Valley Medical Center, CA

July 2009 – June 2010 — Interventional Cardiology Fellowship at Emory University, Atlanta, GA
Program Director: John Douglas Jr. MD
Currently have performed as primary operator approximately 600 interventional procedures over last 12 months.

- Coronary Interventions: over 450 cases including complex multivessel angioplasty, primary PCI and Bypass Graft Angioplasty. Experience includes exposure to use of Rotablator, Angiojet, IVUS, FFR, CFR as well as use of Percutaneous Ventricular Assist Device (Impella/Tandem Heart)
- Structural Heart disease: 50 cases include BAV, Mitral Valvuloplasty PFO/ASD closure, Alcohol Septal Ablation, Balloon Pericardiotomy under guidance of Dr Peter Block.
- Peripheral Angiography/Interventions: 100 cases including management of CLI, Bowel ischemia, Acute Vascular Complications including pseudoaneurysm, Renal and Carotid Angiography/Stenting

July 2006 – June 2009 — Cardiovascular Medicine Fellowship at Keck School of Medicine University of Southern California, Los Angeles, CA.
Cardiology fellowship training program at Los Angeles County General Hospital provided unique experience in:

- Clinical management as well as Cardiac Catheterization in Rheumatic Multi valvular heart disease, Adult Congenital Heart Disease and High risk Pregnancy patients with valvular heart disease.
- Performance of more than 100 Transesophageal Echocardiograms and having read more than 700 Transthoracic Echocardiograms and more than 400 Nuclear Scans.
- Exposure to Cardiovascular MRI under expertise of Dr. Gerald Pohost.

July 2003 – June 2006 — Internal Medicine Residency at Keck School of Medicine, University of Southern California, Los Angeles, CA.

Sep 1995 – Nov 2002 — Medical School at M. P. Shah Medical College, Jamnagar, India with Internship at Sir Gangaram Hospital, Delhi, India

MEDICAL LICENSURE AND CERTIFICATION:

Board certified in Interventional Cardiology - November 2010
Board certified in Echocardiography - October 2010
Board certified in Cardiovascular Medicine - November 2009
Board certified in Nuclear Medicine - October 2008
Board certified in Internal Medicine - August 2006, 90th Percentile
USMLE Step1 and 2 - 2001/2002, 99th/88th Percentile

Level II certified in CT Coronary Angiography- Course Director: Matthew Budoff, MD
Board Eligible for CT Coronary Angiography

Medical Licensure:	Medical Board of California Licensure # A92644. Medical Council of India Licensure # 22339.
ECFMG certification:	Certified on February, 25 2003, ECFMG No: 0-623-272-2 Permanent validation: July 2003
USMLE ID No:	0-623-272-2
AAMC ID No:	11483703

RESEARCH/ABSTRACTS:

June 2009: *The effect of Intra Aortic Balloon Pump (IABP) on Renal Blood Flow (RBF) utilizing direct measurements of RBF by intravascular Doppler technique and renal artery diameter by quantitative angiography in patients undergoing high risk PCI with IABP.*
Poonam Puri MD, Uri Elkayam MD, Anilkumar O. Mehra MD (Principle Investigator)

June 2009: *Role of 3-D Magnetic Resonance Myocardial Perfusion Imaging to detect perfusion deficit across whole LV and compare it with conventional 2-D multi-slice Myocardial Perfusion Imaging.*
Poonam Puri MD, Gerald Pohost MD, Taehoon Shin MD (Principle Investigator).

Jan 2008: Poonam Puri MD, Anil O. Mehra,MD and Uri Elkayam MD
Cheyne-Stokes Respiration and Cardiac Hemodynamics in Heart failure.
Manuscript published in Catheterization and Cardiovascular Intervention Journal. 2008 Oct; 72:4, 581-585

Dec 2007: Vidya Narayan MD, Poonam Puri MD, Anilkumar O. Mehra, MD
A Case of late presentation of CardioSEAL PFO Closure Device Fracture and Thrombus formation 3 years after Device Implantation. Case Report published in The Journal of Invasive Cardiology. 2008;20:E247–E249

Sept 2004: Poonam Puri MD, Radha Sarma MD and Ramdas G. Pai MD
Massive posterior mitral annular calcification causing dynamic left ventricle outflow tract obstruction. Case report published in Journal of American Society of Echocardiography. 2005 Oct ;18:1106

April 2005: Poonam Puri MD, John L Go MD and Soma Sahai Srivastava MD
Intracranial Tuberculoma mimicking Stroke in an immunocompetent patient: Poster presented at Clinical Vignette competition in 2005 ACP-Annual Session at San Francisco.

PROFESSIONAL MEMBERSHIPS AND SOCIETIES:

July 2009-present	Society of Cardiac Angiography and Interventions
July 2006-present	American College of Cardiology
July 2003-present	American Medical Association.
July 2003-present	American College of Physicians/American Society of Internal Medicine.
Nov 2002-present	Indian Medical Association.

VOLUNTEER EXPERIENCE:

Dec 2000	National School Health Checking Program: A nation-wide program in India for the General well being and screening against common illnesses in primary school children, especially in inner city and rural areas.
Dec 1997	Pulse Polio Immunization: A nation-wide program in India for immunization of all children against polio with the aim of eradication of polio. Volunteered for the immunization in the inner-city areas and rural areas for three years.

HONORS AND AWARDS:

May 1993 Awarded National Merit Scholarship for obtaining First rank in All India Board Examination.

REFERENCES:

John Douglas, M.D.
Professor of Medicine
Director Interventional Cardiology & Cardiac Catheterization lab
Andreas Gruentzig Cardiovascular Center
Emory University School of Medicine, 1364 Clifton Rd NE, Atlanta GA 30322
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404-727-7040

Habib Samady, M.D.
Professor of Medicine
Interventional Cardiology
Andreas Gruentzig Cardiovascular Center
Emory University School of Medicine
hsamady@emory.edu
404-778-3204

Peter Block, M.D.
Professor of Medicine
Interventional Cardiology
Andreas Gruentzig Cardiovascular Center
Emory University School of Medicine
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Uri Elkayam, M.D.
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University of Southern California
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Supplemental #2
-Original-

Erlanger East Hospital

CN1502-005

SUPPLEMENTAL #2
February 27, 2015
10:10 am

SUPPLEMENTAL INFORMATION (No. 2)

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger East Hospital

Application To Modernize The Certificate Of Need Originally Issued In 2004 (No. CN0405-047AE) By Upgrading the Cardiac Catheterization Lab To Perform Interventional / Therapeutic Procedures In The Already Approved Diagnostic Cardiac Catheterization Laboratory

Application Number CN1502-005

February 26, 2014

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section C.1, Need (Specific Need Criteria - Cardiac Catheterization), Item 8.

The table listing each cardiac catheterization provider's utilization in the proposed service area and comparing to the 70% capacity standard (70% of 2000 cases) is noted. However, the applicant used "un-weighted" cases from the Joint Annual Report to determine capacity. According to the most recent Certificate of Need Standards and Criteria for Cardiac Catheterization Services the capacity of dedicated and multipurpose cardiac catheterization laboratories is equal to 2000 "weighted" cases per year. The weighted cases are calculated by age group-specific historical state utilization rates calculated from the Hospital Discharge Data System and population estimates maintained by the Tennessee Department of Health. Please request this data from the Tennessee Department of Health and revise the requested utilization chart with "weighted cases" as defined by the Certificate of Need Standards and Criteria for Cardiac Catheterization Services. If this data has already been requested by the applicant from the Tennessee Department of Health, please indicate the status of the data request. If the requested data from the Tennessee Department of Health is received after application completeness, please submit the table listing each cardiac catheterization provider's utilization in the proposed service area and comparing to the 70% capacity standard (70% of 2000 cases) as soon as possible as clarifying information.

Response

The information request to complete the requested data chart was submitted to the Tennessee Dept. of Health on Tuesday, February 24, 2015. As we do not yet have the necessary information we will submit the "weighted" cases data chart as "clarifying information" after the CON application has been deemed.

2.) Section C.1, Need (Specific Criteria - Therapeutic

Cardiac Catheterization), Item 10.b, Access.

Please document that the service area population for Hamilton and Bradley Counties experiences a prevalence, incidence and/or mortality from heart and cardiovascular diseases applicable to cardiac catheterization services that is substantially higher than the State of Tennessee average.

Response

A comparison of mortality per 100,000 population related to heart disease is below.

Comparison Of Age Adjusted Mortality
Per 100,000 Population – Related To Heart Disease

	======== Mortality =========		
	Hamilton County	Bradley County	Tennessee
2005	223	242	245
2006	219	240	233
2007	201	186	223
2008	221	249	226
2009	219	222	213

** NOTES – (1) This information is from the Tennessee Dept. of Health website, *Chronic Disease Health Profile*, December, 2011.

Further, a comparison of the 3 year age adjusted mortality of Hamilton County with the U.S. for heart disease is below.

Comparison Of Age Adjusted Mortality
Per 100,000 Population – Related To Heart Disease

Hamilton County 2007-2009	U.S. 2009	Percent Difference
213.6	180.1	18.6%

** NOTES – (1) This information appears in a study by *The Ochs Center, State of The Chattanooga Region Report - Health*, May, 2013, p. 23.

This data indicates that Hamilton and Bradley counties generally have a higher mortality than Tennessee related to

heart disease. Further, Hamilton County has a mortality rate 18.6% higher than the U.S. due to heart disease.

3.) Section C, Need Item 3.

The county level map of the applicant's service area is noted. However, please submit a revised county level map with only the counties in the proposed service area identified. In addition, please label Georgia service area counties.

Response

A county level map is attached to this supplemental information.

4.) Section C, Need, Item 4.B And (Specific Need Criteria – Therapeutic Cardiac Catheterization), Item 10.a, Access.

Please identify any medically underserved areas in the proposed 2 County service area as designated by the United States Health Resources and Services Administration.

Response

All of Hamilton County and the City of Cleveland in Bradley County have been designated as medically underserved areas.

5.) Section C, Need Item 6.

The table for Erlanger East patient origin by zip code for CY 2014 for zip codes with patient origin over 5% is noted. However, the applicant used the utilization from Obstetric patients to determine a cardiac cath zip code service area. Please clarify how these two patient populations (OB, cardiac cath) correlate (age, diagnosis) in determining a zip code cardiac cath service area.

Response

Since Erlanger East Hospital currently operates primarily as a Women's hospital for Obstetric services that patient origin data was provided. However, as a proxy for what the patient origin data would most likely be when the expansion of the hospital is completed, we have provided the patient origin information for the Emergency Dept. at Erlanger East Hospital for CY 2014.

Zip Code	Patient City	Patient County	Total	Cumulative Total	% By Zip Code	Cumulative %
37421	Chattanooga, TN	Hamilton County	7,945	7,945	35.2%	35.2%
37363	Ooltewah, TN	Hamilton County	3,501	11,446	15.5%	50.7%
30736	Ringgold, GA	Catoosa County	1,379	12,825	6.1%	56.8%
37416	Chattanooga, TN	Hamilton County	1,094	13,919	4.8%	61.6%
		Sub-Total	13,919		61.6%	61.6%
		Other Patients	8,639		38.4%	100.0%
		Total	22,558		100.0%	

6.) Section C, Economic Feasibility, Item 9.

Please indicate how medically indigent patients will be served by the project.

Response

A cardiac patient who, after pre-screening, is is determined to be a low risk and is in need of a cardiac catheterization will be served by the cardiac catheterization laboratory at *Erlanger East Hospital*, regardless of ability to pay. If the patient is determined not to be low risk they will be referred to *Erlanger Medical Center*, regardless of ability to pay.

SUPPLEMENTAL #2
February 27, 2015
10:10 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger East Hospital

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 26th of February, 2015, a Notary Public in and for the
Month Year

State of Tennessee, County of Hamilton.

NOTARY PUBLIC

My commission expires 7 23, 2018.
(Month / Day)

SUPPLEMENTAL #2

February 27, 2015
10:10 am

TABLE OF ATTACHMENTS

SUPPLEMENTAL #2
February 27, 2015
10:10 am

** NOTE - The attachments are paginated and the page number begins with "A". The page number appears in the upper right hand corner of the page.

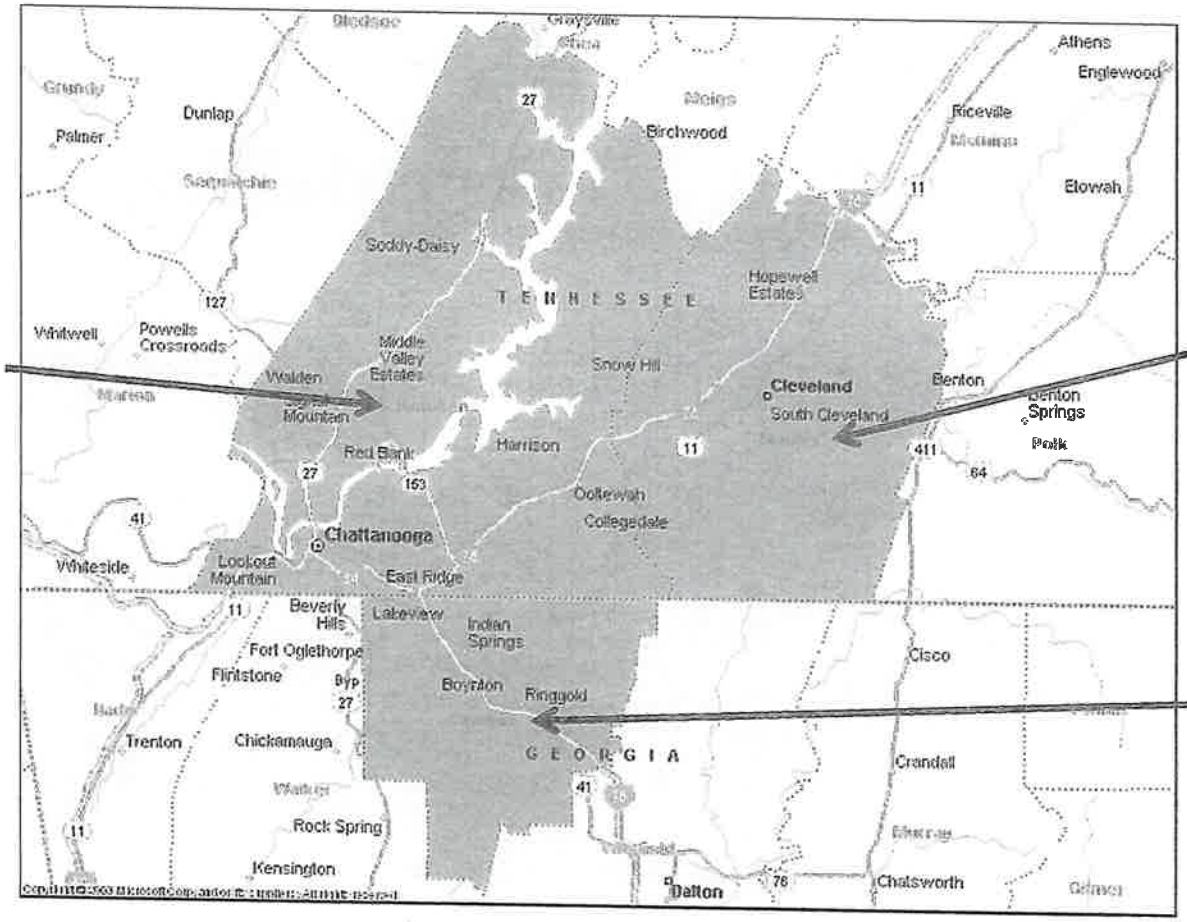
SUPPLEMENTAL #2

February 27, 2015
10:10 am

ATTACHMENTS

Erlanger East Service Area – Counties

Hamilton County, TN



Bradley County, TN

Catoosa County, GA

SUPPLEMENTAL #2
February 27, 2015
10:10 am

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

February 19, 2015

Mr. Joseph M. Winick
Senior Vice President –Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, Tennessee 37403

RE: Certificate of Need Application CN1502-005
Initiation of Interventional (therapeutic) Cardiac Catheterization Procedures

Dear Mr. Winick,

This will acknowledge our February 13, 2015 receipt of your application for a Certificate of Need to perform interventional cardiac procedures at Erlanger East Hospital, 1755 Gunbarrel Road, Chattanooga (Hamilton County), Tennessee.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 p.m., February 25, 2015. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section A, Applicant Profile**

   The applicant references attachments but does not place the applicable attachment item number in the body of the application. As directed in the application, please place all attachments at the back of the application in order and reference the applicable item number on all attachments.

2. **Section A, Applicant Profile, Item 9 Bed Complement Data**

   In the bed complement data chart it is noted the applicant is proposing 113 beds. Please revise and resubmit page 6.

3. **Section A, Applicant Profile, Item 13**

   It is noted the applicant is contracted in the Blue Cross Network E and S. Please provide a brief overview of the two plans and why this is significant to this application.

It is noted the applicant is contracted with "United Healthcare e". Please clarify if the "e" is a typo.

The applicant indicates Erlanger has contracts with Cover Kids and Cover TN. Please clarify if these two plans are still active.

4. Section B. Item I (Project Description)

It is noted the Medical Director of Erlanger's Cardiology service has indicated that it is safer to conduct the therapeutic intervention concurrently than to transfer the patient to another hospital where a second intervention would be required. Please discuss the risks of transferring patients to another hospital for a second intervention.

5. Section B Item Project Description II.B.

The applicant states Erlanger East Hospital holds a CON for the transfer up to 70 additional beds from Erlanger Medical Center. Earlier in the application, the applicant states the number was 79. Please clarify.

6. Section B Item Project Description II.E 1.b and 1.3

The hours of operation for the proposed service are noted. However, please clarify why the proposed service will not be open from 5 pm-7 am, and not open on weekends. During those times where will patients who need therapeutic intervention services be referred?

7. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 3

The transfer agreement with Erlanger East is noted. Please complete the following table:

Hospital	Distance From Erlanger East	Emergency Travel Time from Erlanger East to Erlanger Hospital by ground	2014 # Transfers for open heart surgery	2014 # Transfers for therapeutic catheterization
Erlanger Hospital				

In the transfer policy and procedure, Puckett EMS is listed as the first EMS to be contacted for emergency transfer. Please discuss why this EMS provider is listed as first and what expertise Puckett EMS has in the transfer of cardiac patients.

8. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 7

Please clarify what would be "adequate staff" for the proposed project.

9. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 8

The applicant is adding additional cardiac services. Please address by listing each cardiac catheterization provider's utilization in the proposed service area and comparing to the 70% capacity standard (70% of 2000 cases).

10. Section C. 1. Need (Specific Criteria - Therapeutic Cardiac Catheterization) Item 14

The applicant has only provided Year One and Year Two projected utilization. However, annual volume shall be measured upon a two year average beginning at the conclusion of the applicant's first year of operation. Please revise.

11. Section C. 1. Need (Specific Criteria - Therapeutic Cardiac Catheterization) Item 15

Please clarify if a formal transfer agreement with an open heart tertiary center will be maintained. If so, please indicate the name of the open heart tertiary center.

12. Section C.1. Need, (Specific Criteria, Therapeutic Cardiac Catheterization) Item 16

Please provide the following information for the Erlanger cardiologists that will perform the proposed cardiac therapeutic catheterizations: 1) estimated number of diagnostic cardiac procedures conducted for each of the past five (5) years, and 2) the estimated number of therapeutic cardiac procedures conducted for each of the past five (5) years.

Please provide the names and credentials (i.e., curriculum vitae's and Board Certificates) for the physicians on the hospital's medical staff who will be performing these procedures. Please note those physicians who are board certified invasive and/or interventional cardiologists.

13. Section C.1, Need, (Specific Criteria, Therapeutic Cardiac Catheterization) Item 17

Please clarify if the applicant plans to ever provide therapeutic services on an emergency basis (24/7) in the future. If not, why?

14. Section C.1, Need (Specific Criteria, Therapeutic Cardiac Catheterization) Item 18

Please indicate the number of diagnostic catheterization cases reported to the Tennessee Dept. of Health by Erlanger East for the last two reporting periods.

15. Section C, Need, Item 3.

The county level map of the applicant's service area is noted. However, please submit a revised map with only the counties in the proposed service area identified. In addition, please label Georgia service area counties.

The applicant has defined ten zip codes in the proposed service area. Please provide a map of the 10 zip codes in relation to the proposed 2 County service area.

16. Section C Item 4.A

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	*Hamilton*	*Bradley*	*Service Area*	*TN*
Current Year (2015), Age 65+				
Projected Year (2019), Age 65+				
Age 65+, % Change				
Age 65+, % Total (2019)				
2015, Total Population				
2019, Total Population				
Total Pop. % Change				
TennCare Enrollees				
TennCare Enrollees as a % of Total Population				
Median Age				
Median Household Income				
Population % Below Poverty Level				

17. Section C, Need, Item 4.B

Please identify any medically underserved areas in the proposed service area.

18. Section C, Need, Item 5

Please describe existing cardiac catheterization services in Hamilton and Bradley Counties.

Please complete the following chart for Hamilton and Bradley counties:

Provider Name	Diagnostic Cath Cases			Therapeutic Cath Cases			Open Heart Surgeries		
	2011	2012	2013	2011	2012	2013	2011	2012	2013
Total									

19. Section C. Need, Item 6

Please complete the following chart:

Erlanger Medical Ctr.	**2004**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**2017**
Diagnostic Caths														
Therapeutic Caths														
Total														

Please provide details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Please complete the following table for Erlanger East patient origin by zip code for CY 2014 for zip codes with patient origin over 5%.

Patient Zip Code	Patient City	Patient County	Total	Cumulative Patients	% by Zip Code	Cumulative %
Service Area Sub-Total						
Other Patients						
Grand Total						

20. Section C, (Economic Feasibility) Item 1. Project Costs Chart

The moveable equipment cost of $300,000 is noted. However, please list all equipment over $50,000.

The applicant has specified Technical, Signage, and Environmental in line A.9 with no value assigned. Please clarify.

21. Section C, Economic Feasibility, Item 2

The applicant notes the proposed project will be funded from continuing operation. However, what is the plan if the applicant's net income is less than expected in Year One and Year Two.

22. Section C, Economic Feasibility, Item 1 (Historical & Projected Data Charts)

Please complete a Projected Data Chart for the total cath lab which includes both diagnostic and therapeutic catheterizations.

The Historical Data Chart and Projected Data Charts are noted. Please complete the following tables and place the tables on separate pages labeled 54A and 55A, respectively to be located after the Historical and Projected Data Charts.

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES

	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	*Year*____
1.	$_____	$_____	*$*_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	**$**_____	**$**_____	**$**_____

23. Section C. (Economic Feasibility) Question 6.B

Please compare the proposed cardiac therapeutic catheterization charges to Erlanger Hospital and recently approved Dyersburg Regional Medical Center (DRMC), CN1403-007A.

24. Section C. (Economic Feasibility) Question 7

Please respond to this question specific to the proposed cardiac catheterization service.

25. Section C, Economic Feasibility, Item 9

Please indicate the percentage of total project revenue anticipated from each of TennCare/Medicaid or other state and federal sources for the proposal's first year of operation.

Please indicate how medically indigent patients will be served by the project.

26. Section C, Contribution to Orderly Development, Item 1

Please clarify if the applicant plans to have any transfer agreements outside of the Erlanger Health System. If so, please list.

27. Section C, Contribution to Orderly Development, Item 1

The applicant is projecting 127 and 132 interventional catheterizations in Year One and Year Two that would otherwise be served by another provider. Please describe the effect this proposal will have on the interventional catheterization utilization for providers in the proposed service area.

How will this proposal impact interventional catheterization utilization at Erlanger Hospital?

28. Section C, Contribution to Orderly Development Item 3 (Staffing)

Please provide the current and proposed staffing pattern by completing the following:

Position Title	Current FTEs Existing Cardiac Diagnostic Cath	Proposed FTEs for Proposed Cardiac Therapeutic Cath	Net Change
Total			

29. Section C, Contribution to Orderly Development Item 8 and 9

It is noted the applicant operates as part of the Chattanooga-Hamilton County Hospital Authority. However, please address the following:

Item 8- Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against Erlanger Hospital and/or Erlanger East Medical Center.

Item 9-Identify and explain any final civil or criminal judgments for fraud or theft against Erlanger Hospital and/or Erlanger East Medical Center.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is April 17, 2015. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication

received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Phillip M. Earhart
HSD Examiner
PME

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

February 26, 2015

Mr. Joseph M. Winick
Senior Vice President -Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, Tennessee 37403

RE: Certificate of Need Application CN1502-005
Initiation of Interventional (therapeutic) Cardiac Catheterization Procedures

Dear Mr. Winick,

This will acknowledge our February 25, 2015 receipt of your supplemental response for a Certificate of Need to perform interventional cardiac procedures at Erlanger East Hospital, 1755 Gunbarrel Road, Chattanooga (Hamilton County), Tennessee.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 2:00 p.m., February 27, 2015. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 8

The table listing each cardiac catheterization provider's utilization in the proposed service area and comparing to the 70% capacity standard (70% of 2000 cases) is noted. However, the applicant used "un-weighted" cases from the Joint Annual Report to determine capacity. According to the most recent Certificate of Need Standards and Criteria for Cardiac Catheterization Services the capacity of dedicated and multipurpose cardiac catheterization laboratories is equal to 2000 "weighted" cases per year. The weighted cases are calculated by age group-specific historical state utilization rates calculated from the Hospital Discharge Data System and population estimates maintained by the Tennessee Department of Health. Please request this data from the Tennessee Department of Health and revise the requested utilization chart with "weighted cases" as defined by the Certificate of Need Standards and Criteria for Cardiac Catheterization Services. If this data has already been requested by the applicant from the Tennessee Department of Health, please indicate the status of the data request. If the requested data from the Tennessee Department of Health is received after application completeness, please submit the table listing each cardiac catheterization provider's utilization in the proposed service area and comparing to the 70% capacity standard (70% of 2000 cases) as soon as possible as clarifying information.

2. **Section C. 1. Need (Specific Criteria - Therapeutic Cardiac Catheterization) Item 10.b., Access**

   Please document that the service area population for Hamilton and Bradley Counties experiences a prevalence, incidence and/or mortality from heart and cardiovascular diseases applicable to cardiac catheterization services that is substantially higher than the State of Tennessee average.

3. **Section C, Need, Item 3.**

   The county level map of the applicant's service area is noted. However, please submit a revised county level map with only the counties in the proposed service area identified. In addition, please label Georgia service area counties.

4. **Section C, Need, Item 4.B and (Specific Criteria - Therapeutic Cardiac Catheterization) Item 10.a., Access**

   Please identify any medically underserved areas in the proposed 2 County service area as designated by the United States Health Resources and Services Administration.

5. **Section C. Need, Item 6**

   The table for Erlanger East patient origin by zip code for CY 2014 for zip codes with patient origin over 5% is noted. However, the applicant used the utilization from Obstetric patients to determine a cardiac cath zip code service area. Please clarify how these two patient populations (OB, cardiac cath) correlate (age, diagnosis) in determining a zip code cardiac cath service area.

6. **Section C, Economic Feasibility, Item 9**

   Please indicate how medically indigent patients will be served by the project.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is April 17, 2015. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be

delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ə 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Phillip M. Earhart
HSD Examiner
PME